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Impact Evaluation – CONGO

"Support program for the development of integrated health services for the Republic of Congo"

AID 13158



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The opinions expressed in this document represent the views of the evaluators and do not necessarily coincide with those of the client.

ACRONYMS

AFD	*Agence Française pour le Développpment* (French Development Agency)
AICS	*Agenzia Italiana per la Cooperazione allo Sviluppo* (Italian Agency for Development Cooperation)
BEAC	*Banque des États de l'Afrique Centrale* (Bank of Central African States)
CDP	*Cassa Depositi e Prestiti* (Deposits and Loans Fund)
CNTS	*Centre National de Trasfusion Sanguigne* (National Blood Transfusion Center)
COGES	*Comité de Gestion* (Management Committee)
COPIL	*Comité de Pilotage* (Steering Committee)
COSA	*Comité de la Santé* (Health Committee)
CSI	*Centre de santé intégré* (Integrated Health Center)
CSU	*Couverture sanitaire universelle* (Universal Health Coverage)
DG	Directorate General
DGCS	*Direzione Generale della Cooperazione allo Sviluppo* (Directorate General for Development Cooperation)
DISER	*Direction de l'information et de la recherche en santé* (Directorate of Health Information and Research)
DS	*District sanitaire* (Health District)
EASI	Easy Architecture for System Integration
EM	Evaluation Matrix
EMPA	Extended Minimum Package of Activities
ENI	*Ente Nazionale Idrocarburi* (Italian National Hydrocarbons Agency)
EQ	Evaluation Question
EU	European Union
FGD	Focus Group Discussion
GDP	Gross Domestic Product
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GPW	General Programme of Work
HDI	Human Development Index
HG	*Hôpital Général* (General Hospital)
HRD	*Hôpital de Référence de District* (District Reference Hospital)
IHR	International Health Regulations
KPI	Key Performance Indicator
MAECI	Ministry of Foreign Affairs and International Cooperation
MCIPPPP	Ministry of International Cooperation and Promotion of Public-Private Partnerships
MFBPP	Ministry of Finance, Budget and Public Portfolio
MPA	Minimum Package of Activities
MSP	*Ministère de la Santé et de la Population (*Ministry of Health and Population)
MSPA	Minimum Standard Package of Activities
NGO	Non-Governmental Organization
OECD-DAC	Organization for Economic Co-operation and Development - Development Assistance Committee
PANSS	*Plan d'action national pour la sécurité sanitaire* (National Action Plan for Health Security)
PNDS	*Plan National de Développement Sanitaire* (National Health Development Plan)
PNS	*Politique nationale de santé* (National Health Policy)

PPP	Public-Private Partnership
PSD	Public Service Delegation
RAMU	*Régime d'assurance maladie universelle* (Universal Health Insurance Scheme)
SBS	Sector Budget Support
SDG	Sustainable Development Goals
TBD	“to be defined”
ToC	Theory of Change
ToR	Terms of Reference
TFP	Technical and Financial Partner
UN	United Nations
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNICEF	United Nations International Children's Emergency Fund
UNFPA	United Nations Fund for Population Activities
WHO	World Health Organization

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EXECUTIVE SUMMARY

Context of the initiative

The Republic of the Congo faces significant and persistent healthcare needs, amidst regional and socioeconomic inequalities in access to essential services. The national healthcare system is organized according to a three-tier pyramid: primary care provided by Integrated Health Centers; district referral hospitals; and general hospitals and specialized tertiary care facilities under the direct responsibility of the Ministry of Health and Population. Hospitals' ability to provide adequate diagnostic and therapeutic services remains affected, among other things, by the obsolescence and limited availability of biomedical equipment, the lack of scheduled maintenance, the difficulty in procuring spare parts, and the limited availability of specialized medical expertise.

The strategic framework is the National Health Policy 2018–2030 and the National Health Development Plan (PNDS) 2023–2026. The latter identifies, among national priorities, strengthening healthcare governance and financing, promoting population well-being, ensuring equitable access to quality essential services, and strengthening health security and emergency response. As part of the subprogram for strengthening the provision of healthcare and services, the PNDS envisages maintenance and development interventions for general hospitals and identifies gaps in technological equipment, equipment maintenance, and specialized human resources.

This is the context for the "Support Program for the Republic of Congo for the Development of Integrated Health Services" (AID 013158), funded by the Italian Cooperation. The Program was established following a formal request from the Congolese government and the development of a project document by the Congolese Ministry of International Cooperation and the Promotion of Public-Private Partnerships (MCIPPPPP). The intergovernmental agreement between Italy and the Republic of Congo was signed in Rome on November 25, 2024. The financing amounts to €45 million, of which €35 million is in the form of a concessional loan and €10 million as a grant component; the Program was formally launched on July 15, 2025.

The initiative aims to contribute to improving access and expanding coverage of healthcare services for the Congolese population by upgrading healthcare facilities and achieving service performance standards. The project strategy is based on four integrated dimensions: infrastructure and hydro-energy upgrades; supply, installation, and management of electro-biomedical technologies; training of healthcare and technical personnel; and implementation of an organizational and IT system for equipment management and maintenance. The operational scope includes six general hospitals (Adolphe Sicé, Blanche Gomes, Loandjili, Dolisie, 31 Juillet d'Owando, and Edith Lucie Bongo Ondimba in Oyo) and three secondary or specialized facilities: Makélékélé, Talangaï, and the National Blood Transfusion Center (CNTS).

The chosen financing method is sector budget support (SBS), aimed at enhancing national ownership, alignment with public policies, and the use of partner country systems. The Congolese government has chosen to implement operational activities through a Public Service Delegation (PSD) to a specialized private operator, Althea Emerging Markets Srl.

Objectives and methodology of the evaluation

The independent evaluation was commissioned by Office VII of the Directorate General for Development Cooperation of the Ministry of Foreign Affairs and International Cooperation. It was conceived as an impact evaluation, serving both accountability and strategic learning purposes.

Given the Italian government's interest in considering further funding phases, the evaluation was primarily aimed at providing evidence useful for future planning.

The specific objectives included: analyzing the effectiveness of the intervention and the initial observable effects on the capacity of healthcare facilities to provide advanced care, diagnostics, and effective therapies; assessing the sustainability of the technical-organizational model based on technical laboratories, the EASI (Easy Architecture for System Integration) platform, and training; assessing the internal and external coherence of the Program with respect to national policies, the priorities of the Italian Cooperation, and the activities of other development partners; analyzing the adequacy of the SBS and the governance, monitoring, and financial traceability mechanisms; identifying the necessary conditions for possible subsequent funding phases; and formulating operational recommendations for the Ministry of Foreign Affairs and International Cooperation (MAECI), the Italian Agency for Development Cooperation (AICS), and Congolese counterparts.

The methodological framework followed the OECD-DAC criteria (relevance, coherence, effectiveness, efficiency, impact, and sustainability) and the DGCS Guidelines for Impact Evaluations. A mixed-methods, utilization-focused approach was adopted, integrating: a Results-Based Approach to examine expected outputs and outcomes; a Theory-Based Approach to test the causal hypotheses of the Theory of Change; and a three-step approach to evaluating budget support, consisting of contribution analysis, attribution analysis, and an integrated analysis of evidence.

The evaluation was conducted in three phases: inception, data collection and analysis, and report preparation. The inception phase, held between June and early July 2026, included a kick-off meeting at the Ministry of Foreign Affairs and International Cooperation, preliminary interviews, and review of project, strategic, and monitoring documentation. The field mission took place from July 5 to 19, 2026, in Brazzaville, Pointe-Noire, and Oyo. Visits to healthcare facilities, direct observations of installation areas and technical laboratories, and semi-structured interviews with Italian and Congolese institutions, healthcare and financial stakeholders, hospital management, department heads, and technical staff were conducted. Group meetings were also held with direct beneficiaries, patients, caregivers, and civil society representatives. Discussions with the WHO, UNFPA, UNDP, GFATM, and the World Bank allowed us to assess the initiative's positioning within the framework of international healthcare cooperation in the country.

The analysis encountered limitations in the availability of information. The Project Document deferred the definition of baselines to an initial assessment, which does not appear to have been formalized. The available health data are primarily aggregated at the national or district level and do not allow for the isolation of the intervention's effects in individual departments or target facilities. Furthermore, it was not possible to obtain the full MCIPPPP–Althea EM contract or access the EASI platform data and logs, which are necessary to directly verify contractual performance, response times to failures, equipment usage, and the actual level of autonomy achieved by the facilities. The evaluation therefore based its judgments on the triangulation of available sources (documents, audit evidence, minutes of steering committees, AICS missions, direct observation, and interviews) and adopted a predominantly qualitative approach to assessing the effects and impact.

Main results

The initiative's design addressed the actual structural needs of the Congolese hospital system. The project documentation and evidence collected during the mission confirm the coherence between the three pillars of the intervention (technological modernization, training, and integrated maintenance) and the main critical issues facing healthcare facilities: obsolescence or malfunctioning equipment, difficulties in procuring spare parts, lack of preventative and corrective maintenance, limited technology traceability, and insufficient specialized skills. The Program is also substantially aligned with the PNDS 2023–2026, particularly with subprogram action 3.1, dedicated to the maintenance and development of general hospitals. However, this general relevance was not accompanied by an equally structured identification of needs at the individual facility and department

level. The selection of hospitals and technical priorities was not based on a participatory and documented process involving hospital management, technical and healthcare personnel, and the relevant Ministry of Health departments. Furthermore, training focused primarily on the use and maintenance of equipment, without sufficiently including clinical aspects supporting diagnosis and treatment.

The Program complemented the WHO Cooperation Strategy with Congo 2025–2028 and the process of revitalizing health districts. It focuses on the third level of the healthcare pyramid (general hospitals and specialist facilities), while WHO action is primarily focused on strengthening primary care and district referral hospitals. However, this complementarity has remained primarily strategic and has not translated into a shared operational framework. Alignment with the SDGs regarding strengthening the health system and healthcare workforce capacity is more consistent than with the objectives relating to maternal and newborn health. The nine facilities are concentrated primarily in Brazzaville and Pointe-Noire, with extensions to Dolisie, Oyo, and Owando; their selection was based primarily on population density and the importance of tertiary care facilities, rather than on criteria of territorial equity or prioritization of remote areas.

The use of the Public Service Delegation (PSD) is compatible with the Congolese regulatory framework and, operationally, allowed for the rapid mobilization of logistical, technical, and organizational capabilities for the installation of equipment and the start of maintenance. However, the PSD was defined by the Congolese counterpart as an independent choice and was not specifically negotiated or validated in the main Italian financing approval documents. The intervention was conceived as sector budget support (SBS), based on the principle of government ownership, while its implementation was more akin to an integrated service contract awarded to a private operator. This overlap created a hybrid model, in which the SBS delivery conditions and the PSD contractual objectives were not aligned within a single planning, control, and reporting system. Furthermore, discrepancies were found in the duration of the intervention: the original proposal called for a five-year horizon, the Financial Agreement set a disbursement deadline of 36 months, while the Plan de Travail focused operationally on the first year.

The involvement of the technically competent Congolese institutions was incomplete. The Ministry of Finance, Budget, and Public Portfolio (MFBPP) reported that it was not fully involved in defining the financial procedures; the Ministry of Health and Population had limited participation in the negotiations through the Minister's office, while the various Directorates, particularly the Directorates of Hospitals and Equipment, were not involved in operational management, nor was there any coordination between the various Ministry departments regarding the project. Even the directors of the beneficiary facilities reported, in some cases, that they received equipment without sufficiently detailed prior information on the choices made. Coordination with technical and financial partners was sporadic. The Italian Embassy in Brazzaville played an active role in diplomatic facilitation and institutional coordination, while the lack of a stable AICS technical presence in the country limited continuous support from the initial phase to implementation. The WHO and other UN agencies (UNFPA and UNDP in particular), the GFATM, and the World Bank do not appear to have been systematically involved in the planning of the first phase. In particular, the World Bank, which has invested in equipment at some hospitals, has highlighted the risk of overlap and, at the same time, missed opportunities for integration in the selection of supplies, maintenance, and training.

In terms of efficiency, available evidence suggests significant progress has been made in the implementation of supplies and the establishment of the technical infrastructure required by the Program. Technical laboratories have been rehabilitated and activated in the facilities included in the contract, and call centers are operational to handle maintenance requests. Field observations have confirmed that the targeted departments have been equipped with rehabilitated spaces, equipment, and components necessary for the maintenance of biomedical technologies. However, limitations to the full clinical operability of the equipment remain in some rehabilitated centers, due to the incompleteness of the infrastructure. Although these interventions were formally outside the scope

of the PSD, the lack of prior verification of the enabling infrastructure has limited the potential immediate use of some of the technologies provided.

The EASI system is formally active in the eight facilities within the scope of the contract, with access granted to hospital and ministry focal points, although local staff reported some technical difficulties in entering data. However, the platform still appears to be primarily developed and managed by the private operator. Since the Evaluation Team did not have direct access to the system or its logs, it was not possible to independently verify the performance of contractual KPIs, equipment availability, fault resolution times, and utilization rates. Training, technical support, and skills transfer activities have been initiated, with positive feedback from hospital management and interviewed staff. However, achievement of project targets regarding staff with improved skills is not verifiable without the initial assessment, baseline values, and planned post-training tests. On-the-job support is a promising practice, but it must be consolidated through a formalized, recognized program linked to national human resources planning and university technical training.

The SBS mechanism helped ensure accurate financial reporting and rapid implementation. The conditions for the disbursement of the second tranche were met and accelerated the supply and installation of equipment. However, these conditionalities were essentially financial and measured the level of spending and contractual commitment, without being linked to indicators of technical quality, institutional strengthening, sustainability, or health outcomes. The financial flows of the credit and grant components are separate and traceable back to the operational beneficiary; the audit did not detect any unjustified discrepancies in the reconciliation of disbursements, transfers, and invoices. However, the PSD's flat-rate remuneration model does not allow for an analytical distinction between the resources allocated to supplies, maintenance, and training. It is therefore not possible to precisely assign specific values to the individual financing components, including the grant contribution, which is conceptually intended for capacity building.

The Steering Committee (COPIL) performed an active supervisory role, formulating specific observations on ongoing activities. However, the ability to translate these observations into timely corrective actions remained limited. The logical framework of the AICS Worksheet, the contractual KPIs (Key Performance Indicators) of the PSD, and the Work Plan were not integrated into a single monitoring system; the required baselines were not produced, and the technical monitoring committee envisioned by COPIL is not operational. This resulted in supervision based primarily on audit reports, missions, and qualitative reports, rather than on a coherent set of indicators capable of guiding corrective decisions.

Operationally, the program has seen a rapid start-up and significant technical capacity to execute the service. However, the compression of activities into a few months, compared to a plan originally conceived over a multi-year timeframe, does not yet allow for an assessment of the consolidation of maintenance activities, the effective transfer of expertise, and the sustainability of the model beyond the duration of the PSD. The first observable effects of the Program include strengthening the diagnostic, surgical, and emergency capacity of the nine beneficiary facilities. The intervention has contributed to the availability of more advanced technologies and services, with potential positive impacts on the functioning of emergency rooms, operating rooms, intensive care units, and diagnostic services. However, it is premature to report a measurable reduction in medical evacuations or migration for treatment abroad: these phenomena depend not only on the availability of equipment, but also on infrastructure, medications, specialized clinical personnel, safety of care, referral systems, and the population's trust in local services, as well as on awareness of their existence.

The initiative's effects are currently limited to the target facilities, and no structured mechanisms have emerged to disseminate expertise or extend the model to other hospitals. However, the Program could generate broader impacts if maintenance and training activities were integrated with the Equipment Directorate of the Ministry of Health and Population, if equipment purchased from other partners but not installed or maintained were leveraged, and if structured exchanges between

hospitals were promoted. Looking ahead, sustainability will depend on the ability to make the IT platform and technical laboratories truly appropriate tools for public institutions, to define a supply chain for spare parts and maintenance, to formalize a skills development plan, and to ensure the completion of the infrastructure essential for the use of new technologies.

Recommendations

In light of the evidence collected, the Evaluation Team believes that any further funding phases should be conditional not only on continued supplies, but also on the consolidation of the institutional, infrastructural, and management conditions necessary to transform the outputs already achieved into sustainable results. For simplicity, Phase I hereinafter refers to the Program evaluated here, while Phase II refers to the possible renewal of funding by the Italian Cooperation.

1. **Formalize the scope and logic of Phase II.**
   Before launching Phase II, the parties should adopt a single programming document, approved by COPIL and binding on all stakeholders, which aligns the SBS and PSD implementation methods. The document should clearly define the duration, structures and departments involved, outcomes, activities, budget, roles and responsibilities, monitoring and reporting methods, as well as the conditions for transitioning to subsequent phases.

2. **Establish effective technical-institutional governance.**
   Phase II should include a COPIL with strategic and decision-making functions, supported by a Technical Monitoring Committee coordinated by the Ministry of Health and composed of the relevant ministerial directorates, the MCIPPPP, the Ministry of Finance, hospital directorates, and the Italian National Agency for the Development Cooperation (AICS). The Technical Committee should meet at least quarterly, validate the technical conditions of supplies, develop action plans with responsibilities and deadlines, and formally report to the COPIL.

3. **Ensure integration with policies and partners.**
   Upon the operational launch of Phase II, the Ministry of Health should initiate a technical discussion with WHO, the World Bank, UNFPA, UNDP, UNESCO, and other relevant partners to map existing equipment and investments, identify duplications and gaps, agree on areas of intervention, and develop complementarities in maintenance, training, maternal and child health, and referral systems. The results of the mapping should be updated at least annually and submitted to COPIL.

4. **Building a framework of results, indicators and conditionalities.**
   The first financial disbursement of Phase II should be conditional on the availability of a common monitoring framework, with baselines for each facility and department, annual targets, verification sources, data collection frequency, validation responsibilities, and corrective action thresholds. Subsequent tranches should combine financial conditions and performance milestones related to equipment commissioning, enabling infrastructure, availability of spare parts and consumables, preventive maintenance, EASI functionality, verified training, and effective use of technologies.

5. **Integrate clinical priorities, infrastructure capabilities, and technology supplies.**
   Phase II should be planned as an integrated intervention, in which biomedical technologies, infrastructure rehabilitation, maintenance, availability of spare parts and consumables, and training are inseparable components. Before each investment is approved, a Hospital Development Plan should be prepared and validated for each facility and department, defining clinical priorities, technical and infrastructure requirements, costs, responsibilities, staffing and clinical training needs, completion times, and criteria for testing and full commissioning.

6. **Differentiate the supply, maintenance, and training components in the operational and financial plans.**
   The Phase II operational plan and budget should clearly distinguish between supplies, maintenance, and capacity development, assigning specific objectives, activities, resources, timelines, and indicators to each component. Maintenance should include preventive plans for

the facility, minimum spare parts availability, response times, and intervention records; training should be multi-year and not limited to the installation phase.

7. **Strengthen the transfer of skills and ownership of maintenance systems.**
   Phase II should include an autonomous, funded, and monitored component for skills transfer and public ownership of maintenance. Hospital technicians and ministerial focal points should be identified for each facility, integrated into a progressive program of theoretical training, practical support, exercises, biannual assessments, and skills certification. Verifiable access, roles, and responsibilities for hospitals and technical departments in using EASI should also be defined, ensuring public ownership of the data and platform continuity beyond the support of the private operator.

8. **Connecting strengthened services to the territorial network.**
   For each Phase II hospital, hospital and departmental management should develop a referral plan that identifies available services, clinical referral criteria, referral and counter-referral facilities and contacts, emergency transportation options, and information tools for community providers and the general public. The plan should be developed with the involvement of organizations already active in the community and include monitoring data on the number, origin, and outcomes of referred patients. A community-wide communication and information plan should be developed to publicize the improved healthcare availability.

9. **Define a path to financial sustainability.**
   As part of the SBS agreements, the Congolese side should adopt a multi-year financial sustainability plan that demonstrates the availability of additional resources for preventive and corrective maintenance, spare parts, consumables, EASI connectivity and operation, technical staff, and equipment renewal. The plan should indicate funding sources, budget items, co-financing quotas per facility, and annual commitments from the Ministry of Health and other relevant institutions.

10. **Enhance Phase II as a systemic intervention.**
    Phase II should include a progressive systemic expansion component, defined based on a national mapping of equipment and skills. This component should support the reactivation of unused technologies, the networking of technical laboratories, mentoring between hospitals, the mapping of biomedical technicians, and the adoption of common standards for equipment inventory, maintenance, and management. Its implementation should be contingent on capacity building at Phase I facilities.

1. CONTEXT

1.1. The health situation in the Republic of Congo

Located in central Africa, straddling the equator, the Republic of the Congo covers an area of 342,000 square kilometers. According to the latest General Population and Housing Census (RGPH-5) of 2023, the population of Congo is 6,142,180, predominantly female (50.3%) and characterized by a strong youth presence, with 75.3% of the population under the age of 35. Its annual growth rate is 3.2%.[1] In 2022, life expectancy at birth for the Congolese population was 63.05 years, ranging from 61.5 years for men to 64.62 years for women. Brazzaville and Pointe-Noire, the two largest cities, are home to 58.2% of this population. Population density varies significantly between urban areas (3,646.81 inhabitants/km²) and rural areas (17.96 inhabitants/km²).[2] Law No. 3-2003 currently divides the Republic of Congo into 12 departments, 90 districts, 16 communes, and 23 constituencies.

In 2022, the Republic of the Congo's GDP per capita was approximately $2,520 at current prices, according to the World Bank. The country was classified by the same institution as a lower-middle-income economy.[3] In 2023, the country's Human Development Index (HDI) was 0.593, ranking 149th out of 193 countries.[4] In 2023, the World Bank forecast real GDP growth for the Republic of Congo at 3.5%.[5] This recovery, however, took place in a context of persistent socioeconomic fragilities: unemployment affected around 22% of the total workforce, with youth unemployment estimated at 42% in 2022[6] and the poverty rate was 52.5% in 2020.[7] Social and territorial inequalities also continued to be reflected in access to essential services, including electricity, drinking water, and sanitation, especially in rural areas. According to the UNDP World Human Development Report 2023-2024, the development index for women is 0.564, while that for men is 0.62. According to the most recent UNDP estimates available, based on 2014/2015 survey data, the Multidimensional Poverty Index for the Republic of the Congo was 0.112, and 24.3% of the population was living in multidimensional poverty. A further 21.3% were considered vulnerable to this condition[8].

The right to education and health are among the human rights enshrined in the Constitution of Congo of 25 October 2015. With this in mind, the government adopted Law No. 37-2014 of 27 June 2014 establishing the Universal Health Insurance Scheme (RAMU), amended by Law No. 12-2023 of 10 May 2023, which integrates the previous provisions. The Congolese state remains highly centralized, although Law No. 10 of 2003 transferred certain responsibilities, including primary health care, to local authorities. The health system remains characterized by regional and socioeconomic inequalities, with disparities in access to primary health care between rural and urban areas. These conditions have repercussions on the provision of health services, access to them, and, more generally, on public health and sustainable development.

[1]République du Congo. Recensement Général de la Population, UNFPA 2023
[2] https://fr.countryeconomy.com/demographie/esperance-vie/congo
[3]World Bank, World Development Indicators / Congo Economic Update 2023
[4]UNDP Human Development Report 2023/2024
[5]World Bank, Macro Poverty Outlook: Republic of Congo, Spring Meetings. 2023
[6]World Bank, Strengthening Human Capital for Inclusive and Sustainable Economic Growth in the Countries of Africa Group II. 2023
[7]République du Congo, Plan National de Développement Sanitaire 2023–2026. 2023
[8]UNDP and OPHI, Global Multidimensional Poverty Index 2024: Poverty amid Conflict, Country Profile — Congo. 2024

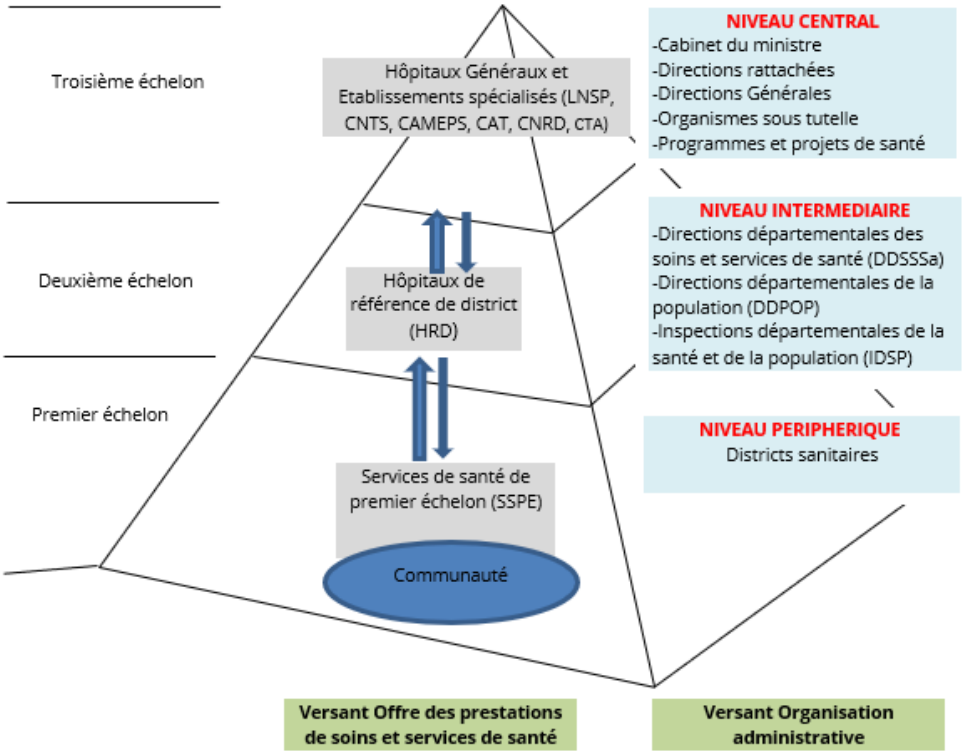
Table 1: Main population health indicators in Congo, 2021-2023

Indicators	Value (per year)
Life expectancy at birth (in years)	63.05 (2022)
Gross mortality rate (per 1,000 inhabitants)	7.3 (2023)
Maternal mortality rate (per 100,000 births)	304 (2023)
Neonatal mortality rate (per 1,000 live births)	20.29 (2023)
Infant mortality rate (per 1,000 live births)	30.73 (2023)
Infant and youth mortality rate (per 1,000 births)	45.94 (2023)
Prevalence of acute malnutrition in children under five years of age (%)	5.2 (2021)

Source: WHO Cooperation Strategy with Congo 2025–2028

The Republic of the Congo's health system is organized according to a three-tier pyramid structure ("échelons"), each with different structures, responsibilities, and objectives, as defined by the National Health Development Plan (PNDS) 2023-2026 and by Presidential Decree No. 551 of October 15, 2020.

Figure 1: Organization of the health system in Congo



Source: Plan National de Développement Sanitaire 2023-2026 République du Congo

The first level corresponds to primary care and is provided by Integrated Health Centers (CSI), dispensaries, infirmaries, and outpatient medical practices spread throughout the area. Its functions include prevention and health promotion, treatment of 90% of common diseases, and rehabilitation (including treatment of malnutrition). The population participates in the management of the district health system through management committees (COGES) and health committees (COSA), community participation bodies that support the functioning of the health system at the peripheral level. First-level health facilities are the first point of contact between the population and the health system and offer a set of activities called the "minimum package of activities" (MPA), based on primary health care. These treatments and services must be accessible (geographically, socially,

financially, and culturally) and acceptable to the populations of the area they serve. Integrated Health Centers are placed under the technical supervision of a health district management team. The integrated health center is responsible for all healthcare services and facilities in the health district in which it is located. CSIs offer a standard package of activities covering information, prevention, treatment, palliative care, and rehabilitation. There are three categories of CSIs:

- CSI with minimum package of standard activities (CSI/MSPA);
- CSI with minimum package of activities extended to childbirth (CSI/EMPA type I);
- CSI with a minimum package of activities extended to basic surgical interventions (CSI/EMPA type II).

The second level is represented by the District Reference Hospitals (HRD), i.e., private hospitals and clinics that serve as reference points for the local CSIs. Together with the first level, this level constitutes the perimeter of the Health District proper, with a management team based at the district hospital and responsible for a defined population and geographical boundaries. Pursuant to Decree No. 2020-552 of October 15, 2020, regarding the responsibilities, organization, and functioning of the management bodies of the district reference hospital, their missions are as follows:

- provide quality promotional, preventive, curative, palliative and rehabilitative care;
- provide pregnant women with quality maternal and child care and services;
- ensure availability and continuity of care for patients, including transfers and referrals;
- participate in the public health actions of the health district, particularly those relating to community health;
- participate in the training of medical, paramedical and support staff in their areas of expertise;
- ensure the management of health information and epidemiological surveillance;
- carry out operational research activities.

The third level comprises the departmental General Hospitals (HG) and health facilities under the direct supervision of the central level of the Ministry of Health, tasked with providing "tertiary-level health care and services". This level is administratively separate from the Health District and is under the direct supervision of the Minister's Office, not the departmental directorates. The operational component is structured through the interventions of 14 specific programs and various projects of varying scope, the most important of which are the Extended Immunization Program (EIP) and the national programs to combat malaria, tuberculosis, HIV/AIDS, and sexually transmitted infections. However, most of these projects and programs remain heavily dependent on international funding and support.

1.2. Strategy and Public Policy

Congo has a National Health Policy (PNS) which covers the period from 2018 to 2030 and has as its vision "a Congo with an efficient, resilient health system capable of ensuring universal access to quality health services and optimal health to sustainably support the country's growth and development"[9]. To achieve this vision, the country has a multi-year National Health Development Plan (PNDS), currently in force for the years 2023-2026. To more effectively regulate the various activities of the health sector, over the past five years the government has developed or revised new legislative and regulatory texts, including i) the promulgation of five new decrees regarding the organization of the Ministry of Health and Population (MSP), the General Inspectorate, and the general directorates, respectively; ii) the adoption of fifteen laws regarding the establishment of all general hospitals and other facilities under their control; and iii) the adoption of an interministerial decree dividing the country into 52 health districts. In accordance with the provisions of the 2015 Constitution and to strengthen local governance in the health sector, several decrees have been published, including those regarding the powers and functioning of the health district management

[9]République du Congo. National Health Policy 2018-2030 (7.1. Vision)

bodies, the management bodies of the CSIs and health centers, and the Departmental Health Council. Despite this progress, the legal framework still suffers from some shortcomings, notably: i) the inadequacy of the implementing texts of the PNDS since its first promulgation in April 1992 and ii) the delay in drafting the implementing texts of the new decree governing the MSP organization.

The country has made significant progress in managing health emergencies, strengthening its capacity to detect, prevent, and contain crises and epidemics. The index of capacity required for managing health emergencies, under the International Health Regulations (IHR), increased from 44% in 2017 to 54% in 2019, while the index of protection against health emergencies increased from 57% in 2018 to 61.2% in 2019.[10] Health emergency preparedness also saw progress, with the score rising from 45% in 2018 to 67% in 2020.[11] The joint external IHR assessments conducted in 2019 and 2023 facilitated the development and implementation of the National Health Security Action Plans (PANSS) 2020-2024 and 2024-2028.

In the area of health security, the country is implementing three regional initiatives: PROSE (Promoting System Resilience to Emergencies), TASS (Transforming Surveillance Systems in Africa), and SURGE (Strengthening and Utilizing Emergency Response Teams). Furthermore, the country has a health security coordination structure aligned with the "One Health" approach, as well as national epidemiological surveillance systems, laboratories, and a Public Health Emergency Operations Center (COUSP). To effectively respond to recurring health emergencies such as epidemics and natural disasters, Congo also developed its own risk mapping in December 2022 using the WHO STAR tool. This exercise identified and analyzed 30 risks, including floods (very high risk), as well as high risks related to epidemics (cholera, yellow fever, measles, monkeypox, etc.) and industrial accidents. The country, which has been free of wild poliovirus for many years, still faces outbreaks linked to vaccine-derived strains.

Some significant challenges remain: i) limited domestic resource mobilization hindering sustainable financing of the PANSS; ii) insufficient surveillance capacity, particularly for drug resistance and healthcare-associated infections; iii) an incomplete event-based surveillance system across all sectors; iv) limited capacity at points of entry in line with IHR requirements; and v) the lack of a functioning national laboratory network.

Congo has recently established a national "One Health" platform, with Decree No. 2024-2696 of November 18, 2024. In line with international agreements, several ministries are engaged in activities related to improving the social determinants of health.[12]For example, with regard to food safety, the Ministry responsible for Industrial Development and Private Sector Promotion serves as the national focal point for the Codex Alimentarius; the Ministry of Agriculture, Livestock, and Fisheries operates the National Centre for Epizootic Disease Control and the National Committee for Pesticide Management. The Ministry responsible for the Environment coordinates the prevention and control of pollution and environmental disturbances and is engaged in a partnership with the WHO national office to promote the triple focus of Health, Environment, and Climate Change. Finally, the Ministry of the Interior, Decentralization, and Local Development coordinates the sections and brigades responsible for urban cleanup.

The Ministry of Health and Population is also intensifying, within the framework of the implementation of the National Health Development Plan (PNDS) 2023-2026, advocacy strategies for the acceleration of achievement of the Sustainable Development Goals (SDGs) related to health. This advocacy activity focuses on the need to honor the commitments made in the 2001 Abuja Declaration, which aim to increase the health budget's share of the overall national budget to 15%. This activity also focuses on strengthening innovative mechanisms to mobilize additional resources at the national level for the health sector. In return, the Ministry of Health and Population must ensure efficient management of all resources, particularly the financial resources mobilized for the

[10]WHO, State Party Self-Assessment Annual Reporting (SPAR) for IHR, République du Congo. Years 2017 and 2019
[11]Ministère de la Santé et de la Population, République du Congo, Plan national de développement sanitaire 2023–2026
[12] https://sgg.cg/JO/2020/congo-jo-2020-02-sp.pdf

implementation of the 2023-2026 PNDS. This management is based on the principles of mutual accountability and responsibility through the strengthening of the monitoring and control mechanism and the periodic review of public health spending. The following table summarises the budget by program line of the PNDS (in millions of FCFA).

Table 2: Budget by program line of the PNDS 2023-2026

PLAN	Year 2023	Year 2024	Year 2025	Year 2026	Total	%
1: Strengthening health sector governance and financing	34 097,67	35 055,92	34 831,67	34 559,92	138 545,18	16.9%
2: Promotion of better health conditions and well-being of the population	12 940,33	80 266,35	150 777,86	224 879,74	468 864,28	57.3%
3: Improving the population's access to quality essential service packages	20 512,07	35 758,82	30 995,32	26 007,04	113 273,25	13.9%
4: Strengthening health security, managing epidemics and other emergency situations	21 940,00	28 216,00	29 064,00	17,742.00	96 962,00	11.9%
Total	**89 490,07**	**179 297,08**	**245 668,85**	**303 188,69**	**817 644,70**	**100.0%**

Source: Plan National de Développement sanitaire 2023-2026

The technical and financial partners (TFPs) supporting Congo in implementing its health policy essentially include agencies of the United Nations system, including the WHO, UNICEF, the United Nations Population Fund (UNFPA), the World Food Programme (WFP), the United Nations High Commissioner for Refugees (UNHCR), the United Nations Development Programme (UNDP), the United Nations Educational, Scientific and Cultural Organization (UNESCO), the Food and Agriculture Organization of the United Nations (FAO), the Joint United Nations Programme on HIV/AIDS (UNAIDS), multilateral cooperation institutions (World Bank; Gavi, the Vaccine Alliance; Global Fund; European Union), bilateral cooperation (France, Russia, the United States of America, China, Italy, etc.), international and national NGOs, as well as religious denominations. The WHO Representative Office also serves in an advisory capacity to the Ministry of Health and Population (MSP), acting as a bridge and facilitating policy dialogue on health issues among TFPs on the one hand, and between TFP s and the Government on the other.

2.SCOPE OF EVALUATION

2.1. The initiative under consideration

The AID 013158 program was designed based on a formal request from the Congolese government and the Project Document submitted by the Ministry of International Cooperation and the Promotion of Public-Private Partnerships (MCIPPPP) to the Italian Government. The program, with an expected duration of 36 months, starting on January 1, 2025, and ending on December 31, 2027, has been classified as untied bilateral aid. The financing, for a total amount of €45 million, was approved by the MAECI's Joint Committee for Development Cooperation with Resolutions No. 109 and No. 110 of September 30, 2024, through a concessional credit pursuant to Article 8 of Law 125/2014 (€35 million, equal to 77.8% of the total) and a bilateral grant component (€10 million, equal to 22.2%). According to the OECD-DAC criteria, the programme is classified in the sectors Health policy and administrative management (10%), Medical services (40%), Basic health infrastructure (30%) and Health personnel development (20%).

The logical structure of the program was divided into two clearly distinct objective levels:

- **General objective**: Contribute to improving access to and expanding coverage of health services for the population of the Republic of the Congo.
- **Specific objective**: Ensure the adequacy of the country's healthcare facilities by achieving a standard of service performance.

The program was structured around three expected results, each with specific indicators and targets:

Table 3: Program Results and Indicators

Result	Description	Main target
R.1	Target healthcare facilities identified and made efficient in terms of infrastructure and energy resources	+40% performance improvement
R.2	Facilities equipped with nationally standardized quality electro-biomedical equipment	Availability (uptime) 96% and utilization rate 80% (quarterly average)
R.3	National healthcare technical platform made functional with trained personnel and operational maintenance systems	75% of staff improved their skills; fault response times: 24 hours for blocking faults, 48 hours for non-blocking faults

The planned activities were to be developed along four complementary axes:

- **Infrastructure adaptation:** structural compliance works and improvement of hydro-energy efficiency;
- **Equipment provision**: maintenance, disposal, and replacement of obsolete equipment; purchase and distribution of new equipment in accordance with international European standards;
- **Staff training**: ongoing training for technical and healthcare personnel on the use and maintenance of equipment; clinical training for specialized medical personnel; recognition of new biomedical engineering professionals at the national level;
- **Creation of technical and management infrastructures**: establishment or revitalization of local technical structures and a central digital coordination center for the management and maintenance of the technical platform.

The chosen implementation modality was Sector Budget Support (SBS), which provides direct support to the Congolese state budget in the health sector. This approach adhered to the ownership

principle, reducing transaction costs for healthcare and granting the Congolese government full control over the programming and use of funds, in accordance with national sector strategic plans. The implementing body responsible for managing the funds is the Ministry of International Cooperation and Promotion of Public Partnership (MCIPPPP), which, in accordance with Congolese law (Decree 2009-156), has decided to use a Public Service Delegation (PSD) to entrust the procurement of goods and services to a specialized company.

The program's approach was designed with long-term sustainability in mind. Continuous training of healthcare professionals, aimed at building stable local expertise in biomedical engineering, combined with the creation of a centralized coordination center to manage the technical platform, was intended to empower the Ministry of Health and Population to manage the equipment independently, without permanent dependence on external support. The program's rationale was also geared toward replicability: the results achieved in the initially selected facilities were intended to provide a knowledge base and a scalable operating model, contributing to the construction of a more balanced and efficient healthcare system throughout the Congolese territory.

The Program underwent a relatively rapid negotiation process between February and September 2024, following the submission by the Ministry of International Cooperation of the Congo of a request for a subsidized loan to finance the contract with a private operator, as part of a program to improve hospital infrastructure. A more detailed document then defined a five-year project, with an estimated total cost of €238 million (equivalent to 156.4 billion FCFA). In September 2024, a Note from the Italian Deputy Minister of Foreign Affairs formally communicated, through the Italian Embassy in Brazzaville, Italy's willingness to mobilize €45 million (€35 million as a subsidized loan and €10 million as a grant), with the prospect of further funding contingent on the results of the initial allocation. Following the Congolese acceptance of this proposal, the Intergovernmental Agreement between Italy and Congo was signed in Rome on November 25, 2024, effectively reorganizing the intervention on this financial basis. The project formally launched on July 15, 2025. The intervention was implemented in six general hospitals (Adolphe Sice, Blanche Gomez, Loandjili, Dolisie, 31 Juillet d'Owando, Edith Lucie Bongo Ondimba/Oyo) and three secondary facilities (Makélékélé, Talangaï, CNTS). The Work Plan, formulated in May 2025, focused the technical intervention on specific priority departments for each hospital (intensive care, operating room, neonatology, emergency room) rather than the entire facility.

2.2. The objectives of the evaluation

This evaluation was designed as an impact assessment, conducted in accordance with the OECD-DAC criteria, with a strategic function distinct from the standard evaluation cycle: it was not limited to reporting the results achieved, but was also called upon to provide forward-looking evidence useful for guiding future programming decisions, in a context in which the Italian government has already expressed its willingness to proceed with financing subsequent phases of the program.

In accordance with the Terms of Reference, the evaluation therefore pursued the following specific objectives:

1. **Effectiveness and impact analysis.** Evaluate the extent to which the intervention has improved the capacity of target hospitals to provide advanced care, quality diagnostics, and effective therapies, analyzing both the directly achieved results (equipment uptime, service continuity, response times to failures) and the initial observable effects on the quality of the population's access to care, particularly for the most vulnerable groups.
2. **Evaluation of the sustainability of the intervention model.** Analyze whether the technical and organizational conditions created by the intervention (hospital technical laboratories, EASI computerized system, staff training, PSD contract) were the most suitable to generate lasting benefits beyond the duration of the Italian funding, with a focus on the effective management

autonomy of healthcare facilities and the Ministry of Health and Population in the maintenance of biomedical technologies.

3. **Verification of internal and external consistency.** Examine the program's consistency with national health policies (PNDS 2023-2026), with the priorities of Italian Cooperation, and with the initiatives of other development partners active in the Congolese health sector (World Bank, AFD, EU), also taking into account the unique nature of the SBS instrument, which recognizes the Congolese government's leadership in implementation and resource management.
4. **Analysis of the SBS modality in relation to the program outcomes.** Since the sector budget support instrument implies that responsibility for implementation lies entirely with the Congolese counterpart, and that the funding is disbursed subject to ex ante conditionalities (submission of the work plan approved by the Steering Committee) and interim audits, the evaluation had to assess the appropriateness of this instrument given the complexity of the intervention, analyzing in particular: the quality of governance and supervision mechanisms, the traceability of expenditure, compliance with disbursement conditionalities, and the efficiency of the use of Italian public resources.
5. **Identifying conditions for subsequent financing phases.** Given that the Italian government has confirmed its willingness to proceed with the financing of subsequent phases of the program following the conclusion of the first phase, the evaluation had to identify the enabling factors and structural risks that may influence the decision to continue the program, providing evidence regarding: the solidity of the intervention model, the replicability and scalability of the results, the institutional adequacy of the Congolese counterpart to manage additional resources, and the most appropriate financing modalities for future phases.
6. **Strategic learning and accountability.** Produce conclusions and recommendations based on objective, triangulated, and credible evidence, enabling the Italian Ministry of Foreign Affairs and International Cooperation to develop an adequate evaluation management response and inform future planning for Italian Cooperation in the Congolese health sector, including within the framework of the Mattei Plan for Africa.

3. THEORETICAL AND METHODOLOGICAL FRAMEWORK

3.1. Methodological framework

The evaluation of the initiative was conducted in accordance with the 2019 OECD-DAC criteria and the DGCS Guidelines for the Impact Evaluation of Development Cooperation Interventions. The evaluation process was explicitly utilization-focused: its conclusions respond to a concrete and urgent need of the Italian Ministry of Foreign Affairs and International Cooperation (MAECI), namely, to have reliable evidence on the results of Phase I to guide the decision on financing a second phase, formally requested by the Congolese government. The entire process respects the principles of utility, credibility, independence, impartiality, transparency, and ethics, in accordance with DGCS standards and the OECD/DAC Quality Standards for Development Evaluation.

The team adopted a mixed-methods approach that combines:

- **Results-Based Approach (RBA)**: for the systematic analysis of evidence with respect to the outputs and outcomes envisaged in the Logical Framework;
- **Theory-Based Approach (TBA)**: to critically examine the causal hypotheses underlying the intervention design and verify ex post the validity of the Theory of Change (ToC);
- **Three-step approach** for the evaluation of budget support: (i) contribution analysis for the input → output chain; (ii) attribution analysis for the outcome → impact chain; (iii) final integrated analysis.

The Theory of Change (ToC) developed in the Inception Report was critically assessed during the field phase, identifying the hypotheses that proved valid, those that failed, and the contextual factors that influenced the causal chain. In particular, the connection between the PSD-based integrated management model and the effective generation of structural autonomy by healthcare facilities, which represents the enabling condition for any additional funding, was analyzed. Based on the reconstructed ToC and the Evaluation Matrix, responses to the questions indicated in the Terms of Reference (ToR) were produced, appropriately redefined and structured around the six OECD-DAC criteria, with particular emphasis on impact and sustainability, given the prospective strategic function of the evaluation. The final Theory of Change and the complete Evaluation Matrix are included as Annexes 4 and 5 to this Report.

3.2. Evaluation phases

The evaluation was structured into three phases: inception, data collection, and report preparation. The urgency of the entire process necessitated a significant reduction in the inception phase schedule, to allow for the field mission to be completed during the first half of July 2026. The inception phase took place between June and early July 2026, following the kick-off meeting held in Rome at the Ministry of Foreign Affairs and International Cooperation on June 18, 2026, followed by the formal launch communication on June 19. During this period, preliminary interviews were conducted with the relevant AICS office, the Italian Embassy in Brazzaville, and several local stakeholders to obtain direct information on the initiative's genesis, planning, and implementation. A preliminary analysis of

the available documentation on the initiative was also conducted. Based on the information gathered, the Team proceeded to assess any information gaps, the conditions for carrying out the evaluation, and the logistics of the field phase. Finally, the detailed timetable for the groundwork phase was drawn up, and the Start-up Report was prepared, presented on July 1st and approved on July 8th, 2026.

Desk analysis. The preliminary meeting allowed for the revision of the ToC and the Evaluation Matrix, while the roles and objectives of the field mission were clarified, distributing the team's presence on site slightly differently: the Team Leader launched the mission and was joined by the health expert a week later, with a three-day overlap. The Team Leader dedicated himself to interviews with institutional stakeholders and joint visits with the Representative of the Italian Agency for Cooperation (AICS), while the health expert primarily attended meetings with other donors operating in the sector, local stakeholders, and direct beneficiaries of the project. Both international experts, supported by the local expert, participated in the program of visits to the hospital facilities involved in the project, developed by the AICS office. It was, in fact, agreed that the field mission should be carried out, at least partially, in conjunction with the monitoring mission planned by AICS at the conclusion of the activities. Since this was a SBS project, the simultaneous presence of independent evaluators and AICS staff, not directly involved in the implementation phase, was not considered an obstacle to the success of the evaluation.

The field mission took place from July 5 to 19, 2026, and included visits to the intervention implementation sites, including health facilities in Brazzaville, Pointe Noire, Oyo, and Owando. Visits, interviews, and focus groups were conducted with key stakeholders and a sample of direct beneficiaries, using semi-standardized interview templates adapted for each stakeholder type. The list of interviewees is included in Appendix 3 of this Report, while an example of an interview template is included in Appendix 6. The entire team worked throughout the mission, continuously sharing findings and in close collaboration with representatives of the Italian Embassy and the AICS office. At the end of the mission, the Team Leader presented the preliminary assessment results in a debriefing session with key local stakeholders; the health expert then continued the meetings, while the local expert helped supplement the documentation with other secondary sources. At the end of the mission, the Team Leader delivered a summary note on the main preliminary results, for use by the MAECI-DGCS. The following table summarizes the timeline of the activities carried out.

Table 4: Timeline of activities carried out during the mission

Day	Place	Activity	Team Participants
05/07/2026	Brazzaville	Meeting with AICS/Embassy	Team Leader
06/07/2026	Brazzaville	Meeting with the Ministry of Health Meeting of the Ministry of Cooperation Visit to General Makelekele Hospital Visit Hospital. Mother Blanche Gomes	Team Leader
07/07/2026	Brazzaville	Visit Bacongo Hospital Visit CNTS Visit Talangani Hospital Interview DG/Hospital Staff. Makelekele	Team Leader Local expert
08/07/2026	Brazzaville	Interview with Director General/Hospital Staff Blanche Gomes	Team Leader Local expert
09/07/2026	Pointe Noire	Visit Loandjili Hospital Visit to the Adolphe Sicé Hospital	Team Leader
	Brazzaville	Health situation data collection	Local expert
10/07/2026	Pointe Noire	Interview with AVSI NGO Manager Interview with Department Manager. Santé Pointe Noire	Team Leader
	Brazzaville	Health situation data collection	Local expert
11/07/2026	Brazzaville	Meeting with EU Cooperation Manager	Team Leader
12/07/2026	Brazzaville	Team Meeting Meeting agenda update. AICS delegate meeting in Abidjan.	Team Leader Health Expert Local expert
July 13, 2026	Brazzaville	Interview Dir. Equipements Min. Santé	Team Leader

Day	Place	Activity	Team Participants
		Interview Dir. Cabinet Min. Finances Online interview with the Minister of Cooperation Councillor	
	Oyo	Visit Hôpital Général Edhit Luicie Bongo Ondimba d'Oyo (Cuvette) Interview with DG Oyo General Hospital Group Interview with Staff of the Maternity, Emergency, Laboratory and Pharmacy Departments of Oyo Hospital; Group Interview with Patients of the Emergency Department and Maternity Unit of Oyo Hospital; Group Interview with Staff of the Technical Maintenance Service of Oyo Hospital Equipment; Interview with the Focal Point for International Cooperation of the Ministry of Health; Interview with the Focal Point for Public Private Partnerships at the Ministry of International Cooperation of Congo.	Health Expert
July 14, 2026	Brazzaville	Online interview with the Director of AICS Abidjian	Team Leader
	Owando	Visit Hôpital Général 31 Juillet d'Owando. (Cuvettes) Interview with the Management and Administration of Owando Hospital; Group Interview with Emergency Room and Maternity Patients; Group Interview with Hospital Equipment Maintenance Technical Service Staff. Visit of the Prefect of the Cuvette Department	Health Expert
July 15, 2026	Brazzaville	Mission debriefing with the Minister of Health, Director of the Administration and Finance Department of the Ministry of Health; Debriefing of the Italian Ambassador and AICS Delegate in Abidjan	Team Leader Health Expert Local expert
		Interview with World Bank Health Officer Interview with WHO Representative	Health Expert Local expert
July 16, 2026	Brazzaville	Interview with the Directorate of Hospitals and the Directorate of Reproductive Health of the Ministry of Health; Group Interview with Patients from Target Hospitals in Brazzaville. UNFPA, CCN-GF, and local NGOs meet Interview with the Rector of the University of Medicine of Brazzaville.	Health Expert Local expert
July 17, 2026	Brazzaville	Interview with the Apostolic Nuncio to Congo; Interview with WHO AFRO, UN Resident Coordinator, UNDP.	Health Expert
July 18, 2026	Brazzaville	Debriefing with the focal point for international cooperation of the Ministry of Health; Contacts with UNESCO and UNICEF.	Health Expert

The reporting phase finally took place between August and September 2026. The Evaluation Team first prepared the draft version of the Report, containing the detailed evaluation analysis by Evaluation Question (EQ), the conclusions, recommendations, and key lessons learned, according to the format included in the ToR. The Report was drafted based on four guiding principles: i) compliance with the evaluation framework and rigor of the analysis; ii) usefulness of the recommendations; iii) effectiveness and accessibility of communication; iv) compliance with international standards. Following the submission of the draft version, a discussion workshop was scheduled to discuss the comments received from the Client, which were subsequently incorporated

into the final version of the document. Once the final Report was approved, a final seminar was scheduled to share the findings, with the participation of key stakeholders.

3.3. Data collection and analysis methods

The evaluation featured a mixed-methods design that combined both primary and secondary data collection techniques, covering both quantitative and qualitative data, allowing the Evaluation Team to gather a wide range of diverse information. The collection tools were selected based on data availability and quality, the individual issues to be examined, and the characteristics of the target groups involved. Furthermore, the nature of the Program, which applied Sector Budget Support with implementation through Public Service Delegation, required a data collection strategy different from that applicable to a directly managed intervention. The funds transferred to the Congolese Treasury budget had to be integrated into the partner country's public finance system, while the technical outputs had to be produced by a private operator operating under a mandate from the MCIPPPP, with no direct relationship with the donor. Finally, the preliminary document analysis identified several critical issues that impacted the methodological approach:

- **Lack of formalized baseline:** the Project Document indicated all baseline values as "TBD—to be identified in the initial assessment report," a conditionality that does not appear to have been formalized. The "Plan de Travail," the document that most closely approximates the characteristics of an assessment, is exclusively operational and financial in nature and explicitly confirms the absence of systematic baseline data;
- **Failure of the Technical Monitoring Committee to function**: foreseen by the Steering Committee (COPIL), this body was not yet active at the date of the last available report;
- **Limited financial traceability**: The COPIL of February 25, 2026, highlighted the need to verify the accounting separation between the credit component and the donation component, and the traceability of Althea's payments to subcontractors, to analyze the quality of Congolese public financial management.

All of this determined the rationale for the data collection strategy, which progressively built convergent evidence from heterogeneous, systematically verified and triangulated sources. We attempted to reconstruct a contextual situation as closely as possible to the project's inception conditions, using data from the Health Information System, the national reports of the PNDS 2023-2026, WHO and World Bank data, and updating them with recent documents. We then attempted to reconstruct, through the documents, the causal chain between financial inputs and political dialogue from Italy and potential changes in Congolese healthcare governance and spending. On the other hand, it was not possible to document the technical performance of the PSD model and the achievement of contractual indicators for the relationship with the private operator, due to the lack of access to the full MCIPPPP–Althea EM contract and the EASI system data.

The analysis was then conducted using a methodological triangulation approach, through which each EQ was examined through the complementary use of multiple sources and tools, thus ensuring the robustness of the evidence collected and the validity of the results obtained.

3.3.1. Desk Analysis

The desk analysis was conducted as a strategic preliminary phase to build the knowledge framework necessary to support the entire investigation process, through the collection and processing of secondary data, both quantitative and qualitative. The documentation examined is divided into three main categories: i) official project documents; ii) materials produced within the project by the various stakeholders involved; iii) regulatory, strategic, and guidance documentation relating to the national and international sector framework. This documentation was initially provided by the Ministry of Foreign Affairs and International Cooperation and AICS, and subsequently supplemented through

direct investigation by the Evaluation Team. To ensure a broad, systematic, and comprehensive review of all available documentation, the collected materials were organized and catalogued in a structured archive. This analysis specifically guided the design of primary investigation tools, ensuring the most comprehensive coverage possible of the study object. Please see Appendix 2 for a complete list of the consulted documentation.

A specific challenge involved reconstructing a reliable baseline, as required in the Inception Report, against which to compare the evaluation results. Its implementation encountered the following concrete obstacles, which made it impossible to execute with the degree of reliability required to support a robust counterfactual assessment within the expected timeframe:

- **Heterogeneity and non-comparability of available sources.** By their very nature, the MSP/WHO national statistics provide aggregate data on mortality and service utilization at the national or district health system level, while no information was available on the project's intervention units (single department/service in the 9 selected facilities), making it impossible to isolate the effect attributable to the project from other system dynamics;
- **Inconsistency with the targets of the logical framework.** The original logical framework, as emerged from interviews with Italian officials, was based on a rather generic needs analysis, lacking in-depth verification, and in any case not supported by direct documentation from stakeholders. Without a documented and traceable needs identification process upstream, any ex-post reconstruction of the baseline through retrospective interviews would have risked being unable to be anchored to specific original targets compatible with the initial logical framework.
- **Unable to access EASI logs from first inventory.** The initial inventory of equipment was carried out manually by the private operator, without a pre-existing inventory, using a proprietary coding system not designed for evaluation or comparison purposes. Due to confidentiality concerns, it was not possible to acquire the EASI system reports, either during the desk or field phases.

3.3.2. Field analysis

The field analysis was designed as a component of the research methodology to gather primary evidence through direct engagement with project stakeholders and beneficiaries. This enabled us to verify previously processed secondary data by triangulating it with new information, perceptions, and causal connections that desk analysis is difficult to capture. In conducting the analyses, the team applied a participatory method, which involves considering a variety of values and perspectives, addressing the interests of diverse stakeholders, and fostering collaborative relationships during meetings. The activity benefited from the fundamental support of the Italian Embassy in Brazzaville, which facilitated initial contact with the various stakeholders and supported the Evaluation Team throughout the entire research process, fostering credibility and promoting the cooperation necessary for the research's success. The field analysis was conducted primarily through three data collection tools: i) direct observations in the hospital facilities involved in the project; ii) semi-structured interviews with institutional stakeholders and key witnesses; iii) collective interviews with groups of beneficiaries and patients.

At the facilities visited, a physical inspection was conducted of the equipment installation areas, the hospital's technical laboratories, and the infrastructure upgrades made (electrical, plumbing, and air conditioning systems), as well as the availability of operational and maintenance documentation in the departments. Semi-structured interviews focused on bilateral governance (MAECI-DGCS, AICS Abidjan, the Italian Embassy, and the Ministries and Territorial Directorates involved), healthcare governance (MCIPPPP and MSP/DG Equipment), and operational structures (hospital management, department heads, and technical staff). The intervention's external coherence and the presence of synergies or overlaps with other programs in the Congolese healthcare sector were verified with international stakeholders operating in the country (WHO Brazzaville, UNFPA, Global

Fund, and World Bank). Finally, group interviews focused on healthcare and technical staff, patients and their companions, and civil society workers.

The data collection methodology took into account the evaluation's objectives and its objective limitations, particularly the nature of the indicators formulated for the project and the extremely short implementation timeframe compared to the original project design. The indicators defined in the logical framework were largely implementation or process-related, rather than indicators of effect or impact on the population's health. This made it structurally difficult to infer from the achievement of these indicators a real improvement in diagnostic and therapeutic capabilities, furthermore, as previously mentioned, there was no defined baseline values. The contraction of the planned three-year intervention to just a few months also structurally reduced the possibility of observing medium-term effects (changes in healthcare use behavior, consolidation of technical skills, etc.), which by their nature require a longer time horizon than that which has elapsed since the project's operational launch. For this reason, a predominantly qualitative evaluation approach was adopted, oriented toward proxies of satisfaction and functionality, rather than a rigorous measurement of impact in the strict sense.

4. EVALUATION RESULTS

4.1. Relevance

Q.1. To what extent did the decision to intervene in 9 hospital facilities with an integrated technological management model respond to the priority diagnostic and therapeutic needs of the Congolese healthcare system?

- The project documentation confirms a substantial coherence between the three pillars of the intervention (technological modernization, training, and integrated maintenance) and the structural deficiencies identified in the Congolese hospital system, although there were limitations in the effective operational implementation of the interventions at the individual facility level, in terms of involvement and identification of priorities.
- The evidence collected indicates that the Public Service Delegation (PSD) mechanism, based on a sector budget support (SBS) logic, was theoretically consistent with the principle of government ownership promoted by the Italian Cooperation, but its practical application showed significant limitations, linked to difficulties in cross-sector governance among the various local institutions and to the poor integration between the two management mechanisms (SBS and PSD).

D.1.1 Did the three pillars of intervention (technological modernization, training, integrated maintenance) correspond to the most critical deficiencies of the target hospitals?

The Project Document clearly identified, in the needs analysis section, a series of structural critical issues in the Congolese healthcare system that justified the three-pronged approach to the intervention. The document highlighted how "obstacles to improving healthcare provision include the limited availability of equipment and instruments, medicines, and the shortage of qualified and motivated healthcare personnel." In particular, it described an "alarming" state of maintenance and support for biomedical equipment, summarized in a table of problems/mitigation strategies that listed: obsolescence and malfunction of medical equipment, lack of skills among medical and technical staff for proper use and maintenance, limited availability of spare parts, and inadequate traceability of equipment and its maintenance.

Each of these shortcomings directly corresponded to a line of intervention in the project. The replacement of obsolete equipment and the installation of new technologies address the problem of technological obsolescence; ongoing training programs for healthcare and technical personnel, focusing on both the use and maintenance of equipment, address the skills gap; and the establishment of regional maintenance centers and computerized asset management systems address the maintenance and traceability gap. This logical architecture is explicitly summarized in the program's key activities: infrastructure and hydro-energy upgrades, installation of new equipment to meet European standards, maintenance of electromedical equipment, and replacement of obsolete equipment.

The three-pillar design is also aligned with the sectoral diagnosis of the National Health Development Plan (PNDS) 2023-2026, referenced in the Project Document itself as a strategic reference. The PNDS identifies the sector's key challenges as "providing health centers with adequate equipment, medicines, and human resources" and "effective management of healthcare human resources,"

challenges that the project's three pillars translated operationally into concrete activities. The initiative was explicitly included in strategic axis 3 of the PNDS, dedicated to strengthening the provision of quality essential healthcare and services, confirming that the project's tripartite approach reflected the national priorities already outlined in the Plan.

The results of the evaluation mission therefore confirm, at a general level, that the project is aligned with the national strategy and that the services offered under the three pillars are consistent with the needs of the facilities. However, it is necessary to highlight several critical elements: first, the decision to intervene in a limited number of facilities, understandable in terms of efficiency, was not supported by a participatory process, nor were the criteria for the choices made explicitly stated. Furthermore, there was a lack of adequate prioritization at the micro level, that is, at the individual hospital facility. The interviews conducted confirmed that there was no real on-the-ground consultation with operators at the departmental level or within each hospital to gain a preliminary understanding of their needs and challenges, which sometimes resulted in the introduction of supplies in less than fully adequate settings. This gap between theoretical relevance and practical application also emerges in the analysis of the training component: observation shows that training was limited to the use of equipment, while there was a lack of support for the accuracy of equipment-assisted diagnosis. This indicates that the training pillar did not address all aspects of the skills gap identified in the needs analysis phase, which included not only the use but also the maintenance and, implicitly, the clinical appropriateness of the equipment provided.

D.1.2 Was the PSD approach appropriate to the Congolese institutional context, or were there more effective alternatives?

Decree No. 2009-156 of May 20, 2009, concerning the Public Procurement Code, devotes Chapter 6 (Articles 77-83) to Public Service Delegations. It defines a PSD as "a contract by which a public or private law entity...entrusts the management of a public service under its jurisdiction to a delegate, whose remuneration is tied to or substantially guaranteed by the results of the service's management." The core principle of the model, therefore, is the delegate's remuneration primarily through the results of the service's management/operation, through the assumption of the associated operational and financial risk. In this specific project, the approach was substantially different, as the operator was not remunerated through fees paid by end users (public hospitals do not charge market rates for healthcare services), but through a fixed fee financed by the public budget (i.e., Italian funds), constituting a hybrid model closer to a "global service" contract than to a public service concession.

The Project Document further justified the choice of the sector budget support mechanism by invoking the "principle of ownership," according to which this approach recognizes the central role of local government in the implementation of sector strategic plans, fostering improved governance and management capacity at the local level. The choice was also based on the country's previous positive experiences with other partners, such as the World Bank and the French Development Agency (AFD), which should have provided a well-established institutional foundation upon which to build the Italian intervention. At the implementation level, the Congolese government then chose to entrust operational management to an international private operator (Althea Emerging Markets srl) through a Public Service Delegation (PSD). The stated goal was to achieve higher service quality by setting objectives with a private operator and to overcome the previous autonomy of individual hospitals in procurement and equipment provision, aiming for standardization of supplies.

Interviews conducted with Congolese ministerial representatives also revealed significant institutional fragmentation. The Congolese Ministry of Finance reported that the Program was effectively managed as an ordinary project, emphasizing that the Ministry was not involved in defining the financial procedures for budget support and that the funds were not allocated directly by the Ministry of Health and Population, despite the latter being the central player in a budget support mechanism. This misalignment between the declared logic (SBS) and the management practices

applied through the PSD constitutes one of the main institutional criticalities identified by the evaluation, as the procedures and implementation methods were defined independently of the project design and BS practices, creating difficulties in interpreting the project's duration, administrative procedures, and even the measurement of results.

Added to this is a problem of intersectoral governance: the Ministry of Health and Population has a dedicated Equipment Directorate, which was not involved in the negotiation and management of the project, resulting in the Directorate itself "possessing little information on the project, its implementation, and its modalities." This limited participation by the technically competent Ministry (already critically highlighted by the preliminary missions conducted by AICS in 2024) effectively weakens the institutional ownership argument underlying the choice of the SBS, since the decision-making process, which is concentrated in the Ministry of International Cooperation, has been poorly shared with the relevant health authority.

On the operational level, interviews with hospital directors also provided a more positive picture of the effectiveness of the outsourcing of services to the private operator: at Talangaï hospital, managers report that the impact "has been significant" and that, thanks to the continued presence of the company's technicians, "there are no longer any problems with the procurement of biomedical materials." However, the same staff members report that the planned transfer of expertise to local technicians remains partial, as interventions are conducted exclusively by technicians from the outsourced company rather than internal staff, a factor that raises the question of the long-term sustainability of the PSD solution once the contract with the private operator expires.

The evidence collected therefore suggests that the PSD model was not inappropriate in principle, being consistent with positive precedents in the country and aiming to strengthen technological quality and procurement efficiency. The problem encountered lies rather in the mechanism's hybrid application: the overlap between a budget support approach (which would require the resources to be allocated to the ministerial budget and managed by the Ministry of Health and the Ministry of Finance) and a de facto management approach more akin to a traditional project, managed by a single ministry (International Cooperation) in direct agreement with a private operator, without full involvement of the relevant technical structures.

D.2 To what extent was the intervention design aligned with national health policies (PNDS 2023-2026), the WHO strategy (13th GPW) and SDGs 3.1, 3.2 and 3c?

- The intervention is substantially aligned with the PNDS 2023-2026, falling within Action 6 of Sub-program 3.1 dedicated to General Hospitals, and responds to the technological deficits and the lack of a maintenance strategy identified by the Plan.
- Compared to the WHO strategy (13th GPW and Congo Cooperation Strategy 2025-2028), the Italian Program is positioned downstream and in complementarity with the WHO action on health districts, strengthening the third level hospital-tertiary care in line with the healthcare pyramid on which the national system is structured, with Italy explicitly mentioned as a potential partner in priorities 1, 2 and 3 of the WHO strategy.
- Alignment with SDGs 3.1 and 3.2 (maternal and neonatal mortality), on the other hand, is weak: the selection of the nine hospitals followed criteria of population density rather than territorial equity or maternal and child priority, the maternity/neonatal component remained secondary in implementation practice, and key stakeholders such as UNFPA or the Directorate of Reproductive Health were not involved. For SDG 3c (strengthening health personnel and capacities), the Program contributed more solidly, through training and technological maintenance, albeit without full intersectoral coordination.

D.2.1 Did the programme contribute to strengthening the second phase of the national strategy for the revitalization of advanced health services?

The program funded by Italian cooperation fits coherently with the hospital development component envisaged in the PNDS 2023-2026, although the terms "second phase" and "advanced health services" used in the project documents are not reflected in the official planning of the national plan. The Project Document, in fact, described the intervention as part of "Phase 2: Development of Advanced Health Services," following an initial phase of "Reinforcement of Primary Health Services" implemented by the WHO in health districts. This two-phase sequential structure, however, does not correspond literally to the PNDS 2023-2026, which does not organize its interventions by temporal phases but by transversal Programs and Sub-programs, applied simultaneously at all levels of the healthcare pyramid (CSI, HRD, HG). The "second phase" should therefore be understood more as a narrative representation used to place the Italian Program within the framework of the strategy agreed with WHO and not as a formal stage present in the PNDS.

The same Project Document explicitly frames the intervention in relation to "Actions 1-5-8 of Sous-Programme 3.1" of the PNDS, which however concern mainly the Health Districts: Action 1 concerns the revitalization of the health districts and the CSI, Action 5 concerns the Hôpitaux de Référence de District (second level, not the HG), while only Action 8, relating to the safety of the transfusion chain, is functionally linked to the CNTS included in the project. The PNDS action actually dedicated to the General Hospitals is no. 6, and it is therefore possible that the misalignment in the Project Document was due to the reference to a previous version of the PNDS.

In any case, the program fell substantially within Action 6 of Subprogram 3.1 ("Strengthening the offer of health care and services"), which is dedicated to the maintenance and development of General Hospitals, and which explicitly includes the target hospitals of the Italian project. Furthermore, the project, through the renewal of biomedical technologies, staff training, and the strengthening of maintenance, directly responds to the problems that the PNDS itself identifies in Program 2: lack of technical equipment in healthcare facilities (CSI, HRD and HG) and the absence of a national strategy for the maintenance of technological equipment.

The entire health development strategy is also based on collaboration with the WHO, in accordance with the Republic of the Congo's commitment to collaborate in promoting the 13th General Programme of Work. The WHO itself has developed its own Cooperation Strategy for the Congo (SCP) for the years 2025–2028, which is divided into five strategic priorities and explicitly covers all three levels of the health pyramid, in explicit connection with the Congolese PNDS.

Table 5: Comparison between SCP-WHO and PNDS

N.	SCP Priority	Priorities of the PNDS 2023-2026	Levels of the pyramid covered
1	Strengthening national capacities to promote better health and well-being of the population	Promotion of better health and well-being for the population	Cross-cutting (community, social determinants)
2	Strengthening national capacities in governance, health sector financing, and human capital development to achieve universal health coverage (UHC) and expand primary health care	Strengthening health sector governance and financing	All levels of the health pyramid
3	Strengthening the implementation of the operational strategy for primary health care; improving the provision of quality health and social care and services – particularly for mothers, children and minorities at all stages of life – and ensuring equitable access to them	Improving equitable access of the population to quality essential service packages	SSPE (1st level), district hospitals (2nd), hospitals able to offer specialist care (3rd)

4	Strengthening health security, prevention and response to health emergencies, within the framework of a multisectoral and "One Health" approach	Strengthening health security and managing epidemics and other emergencies	Transversal (One Health)
5	Strengthening the effectiveness and flexibility of the WHO Country Office in Congo in supporting the Government and coordinating partners	Strengthening health sector governance and financing	Institutional

Source: Evaluation team processing

From an operational perspective, the WHO strategy focused primarily on revitalizing Health Districts (HDs) and promoting primary care. The Italian program, on the other hand, aimed to strengthen the hospital-tertiary component of the Congolese health system, acting on an institutional structure distinct from the system of health districts, since the tertiary level is directly under the central control of the Ministry of Health, while the HDs only comprise the first and second levels. It can therefore be concluded that the Italian project is part of the WHO operational program, following the logic of the health pyramid envisaged by the PNDS and shared by both interventions, with an alignment documented in the project documents themselves. It is important to note that the WHO, in the section of its strategy dedicated to coordinating international partnerships, also includes Italy among the potential partners for priorities 1, 2, and 3.

D.2.2 Were vulnerable groups (women, newborns, geographically disadvantaged areas) explicitly included in the design?

The Italian intervention focused on nine facilities, six in urban areas and three in peri-urban areas, located in the country's two largest agglomerations (Brazzaville and Pointe-Noire, which house 58.2% of the national population). These areas cannot be defined as geographically disadvantaged, but rather as areas with a high population density: the site selection criteria were therefore guided by population density and the importance of tertiary care, rather than by a criterion of territorial equity favoring the most disadvantaged or remote areas of the country.

The project design included, among the components to be equipped, the renovation of operating rooms, laboratories, maternity wards, and the emergency room, suggesting a formal focus on maternal and neonatal care. However, in actual implementation, maternity wards, delivery rooms, and neonatology wards were not the primary targets of the intervention, while the Medical Directors of the participating hospitals themselves complained that they were not involved in setting priorities. Based on the feedback gathered, in a future phase, the priorities will be collected directly from the Medical Directors of each hospital, indicating that the inclusion of specific needs related to maternal and neonatal mortality (recognized as one of the leading causes of mortality in the country) was not structured ex ante in the initial design, but remains an intention to be consolidated in subsequent phases.

A critical finding concerns the lack of involvement, during the design phase, of the departments and agencies specifically responsible for vulnerable groups: the evidence collected does not show that various departments, such as the Department of Reproductive Health, Hospital Management, and Equipment Management, were involved, nor were United Nations agencies such as UNFPA, WHO, or the World Bank, the latter having its own project for equipping referral hospitals. This confirms that the Italian program design was not coordinated in a structured manner with the actors in the Congolese health system who have a specific mandate for maternal and child health, which is otherwise covered by Subprogram 3.3 ("Reinforcement of mother and child health programs") of the PNDS, which is a dedicated axis distinct from Subprogram 3.1 to which the Italian project refers.

The interviews also highlighted a gap in the actual accessibility of healthcare facilities for populations in the most remote areas: beneficiaries reported that "several mothers arrive by canoe from the Congo River and die in the canoe. Others die on the way to a health center to give birth." The project,

focusing on urban referral hospitals, did not include complementary components such as waiting centers for mothers with complications or a safe transportation system from peripheral health centers, "a network... yet to be created," according to the source, raising the need for a specific project component, possibly involving NGOs with previous experience in the area.

The evidence collected therefore points to partial and unintentional inclusion rather than vulnerability-focused planning. In the original design, vulnerable groups were not explicitly incorporated as a guiding criterion: the selected areas responded to a rationale of demographic concentration rather than geographic disadvantage, the maternal-neonatal component remained secondary, and no solutions were provided for the accessibility of the most isolated populations.

4.2. Coherence

Q.3. Is the PSD model with a private operator coherent with the Congolese regulatory framework and with the Italian Cooperation policies regarding public-private partnerships in healthcare?

- The choice of the PSD is coherent with the Congolese regulatory framework (Decree n° 2009-156) but was decided unilaterally by the Congolese Government as an implementation method without being negotiated or validated by the Italian party in the official approval documents (CC Resolution 109/2024, DGCS Note, Intergovernmental Agreement), which only generically mention a possible Public-Private Partnership scheme and the use of a private operator.
- Compared to Italian cooperation policies, the initiative was conceived as a Sectoral Budget Support based on the principle of government ownership, while the PSD introduces a different logic, based on a bilateral contractual relationship between the government and the private operator, generating an underlying tension between the two governance approaches.
- A practical misalignment was highlighted between the two reporting mechanisms (SBS conditionality vs. PSD contractual KPIs) and some inconsistencies regarding the program's duration (5 years in the original agreement, 36 months in the Financial Agreement and the Work Plan). These critical issues did not impede the technical implementation of the planned activities, but they do point to a deficit in institutional construction, with poorly communicated implementation mechanisms.

D.3.1 Was the use of the Public Service Delegation discussed and agreed upon with the Italian Government when the initiative was approved?

The official documents with which Italy approved the initiative do not make specific reference to the PSD instrument. Resolution No. 109/2024 of the Joint Committee for Development Cooperation, which granted the €35 million soft loan, refers exclusively to the Congolese government's request, the AICS evaluation form, and the debt sustainability analysis prepared by Cassa Depositi e Prestiti, without any reference to the implementation method chosen by the other party, except in terms of the possible use of the Public-Private Partnership (PPP) implementation model. Similarly, the DGCS Information Note prepared for presentation to the Joint Committee describes the initiative's management and implementation methods exclusively in terms of support for the Congolese budget, specifying that the Congolese authorities would develop, after the entry into force of the Intergovernmental Agreement, a reference document to identify the healthcare facilities targeted by the initiative and indicate the starting conditions and needs. The Intergovernmental Agreement signed in Rome on November 25, 2024, also does not mention the PSD: it defines the parties' obligations, the interveners (MAECI-DGCS, AICS, CDP for Italy; MCIPPPP, MFBPP, BEAC, MSP

for Congo) and the control procedures through the Steering Committee, but leaves the Congolese party full autonomy over the implementation methods.

On the other hand, the Project Document and the formal funding request formulated by the Congolese Government in September 2024 explicitly mentioned the "Public Service Delegation" as the implementation instrument "desired" by the Congolese government, while an explicit reference to Decree No. 2009-159 (actually No. 2009-156) appears only in the "Work Plan, Timetable and Cost Details," a document drafted by the Congolese side after the funding was approved. This is therefore an autonomous Congolese act within its project implementation prerogatives and communicated to the AICS as a consolidated fact, not a modality previously negotiated with the Italian side during the approval of the initiative. The interview with the Ministry of International Cooperation's head of public-private partnerships confirmed that the decision to use public service delegation was an internal one, motivated by the desire to "achieve higher quality by defining objectives with a private operator," while the company's choice was based on its consolidated operational presence in the Congo's healthcare sector.

Interviews with the Italian officials involved confirmed this reconstruction. The Director of the relevant AICS office stated that the project was implemented through the public service delegation mechanism, the contractual instrument of which was not agreed upon. This demonstrates that AICS had no role in negotiating or validating the PSD contract between the Congolese government and the private company Althea EM, entrusted with the execution, nor in the selection process for the private company itself. The representative of Cassa Depositi e Prestiti also characterized Italy's role as merely a provisional one, with no reference to any involvement in the selection of the PSD. On this basis, it can be argued that the use of the PSD pursuant to Decree No. 2009-156 was decided unilaterally by the Congolese government as a means of implementing the program, and that the contractual relationship between the Congolese government and the private executing entity was interpreted by the other party as an act independent of the execution of the project, discussed well before the Italian intervention and unrelated to the requirements of the financed project.

It is important to note, however, that this programmatic choice is at the root of a discrepancy in interpretation that has affected the entire project implementation. The official project documents are not explicitly and precisely aligned with those governing the PSD: although it was not possible to review the latter, the evaluation evidence points instead to a parallel process, with differing indications regarding duration, objectives, and activities. Specifically, regarding the operational duration, the original proposal, whose financial plan is attached to the Intergovernmental Agreement, was structured over five years with disbursements in 20 quarterly installments; the Financial Agreement (January 2025) set the disbursement deadline (*délai de tirage*) at 36 months from signature; Finally, the Plan de Travail (June 2025), which refers to the PSD, reports “36 months” in the heading as the duration of the program, however the attached timetable and expenditure plan cover only “the first of the five years envisaged by the project”, maintaining the five-year logic of the original project.

D.3.2 Have tensions emerged between the logic of SBS (government ownership) and the logic of PSD (private management with KPIs)?

The AICS Evaluation Form explicitly defines the initiative as a Sector Budget Support Program, based on the "principle of ownership" and the decision to recognize "the central role of local government in the implementation of strategic sector plans." The document specifies that "the initiative will therefore be managed directly by the counterparty," outlining a model of accountability and control fully vested in Congolese institutions. The Project Document, however, introduces a different element into its institutional architecture: it stipulates that, "within the framework of a public service delegation, in accordance with local legislation, certain activities may be entrusted to a private company of international standing," effectively entrusting operational management to a

private entity remunerated through lump sum payments. These are two intrinsically divergent governance approaches: one based on ownership and widespread public responsibility, the other on a results-oriented bilateral contractual relationship between the government and a single private operator.

The evaluation mission revealed that the contractual timeframes of the PSD with the private operator and those of the Italian financial agreement were not organically synchronized, nor were their respective reporting methods: the AICS stated that the Steering Committee merely validated the auditor's reports ex post. Furthermore, neither the WHO nor other multilateral bodies were involved in the project, a clear indication of the misalignment with the donor harmonization approach typical of the SBS.

Tensions were concretely manifested in the financial and accountability spheres: interviews with Ministry of Finance officials revealed a significant anomaly in the management mechanism for funds classified as budget support, where the fungibility of resources and their inclusion in public accounts are essential requirements. Interviews and minutes of COPIL meetings reveal that, although the Committee itself was extremely effective, its ability to accurately track SBS conditionalities against specific PSD results remained rather weak, lacking any feedback against the specific KPIs negotiated within the PSD. The Interim Audit Report, while confirming substantial consistency between planned and implemented activities at the technical level, focused exclusively on verifying the compliance of the services performed with the Work Plan (i.e., the typical PSD result-based approach), without ever relating this verification to the disbursement conditionalities typical of the SBS, indirectly confirming the de facto separation between the two reporting mechanisms.

The identified tensions did not, however, prevent the technical implementation of the activities envisaged in the Work Plan, which the audit report deemed substantially consistent with the plan. However, they do highlight a deficit in institutional planning: the overlapping of the two approaches would have required, starting from the approval phase, explicit mechanisms to link budgetary conditionality and contractual KPIs, which in practice remained parallel and poorly connected.

Q.4. Were duplications with other donors active in the Congolese health sector (EU, World Bank, WHO, UNICEF) avoided and available synergies maximized?

- The Italian program was part of a context characterized by the presence of other partners active in strengthening the health sector; the simultaneous implementation of investments by the World Bank in the same sector highlights the need to consolidate prior discussions on supplies and the allocation of intervention areas, which has not occurred at this stage.
- The exchange mechanisms established with international partners and national technical bodies have provided an initial basis for dialogue, which, however, has proven to be rather sporadic. Internal coordination has been limited to COPIL meetings only and should be further structured through more regular involvement of the Ministry of Health directors, hospital directors, WHO, UNFPA, and other technical and financial partners.
- Strategic complementarity with the WHO health district revitalization program was identified but not fully capitalized on, as the Italian intervention shared only the higher-level strategic references (PNDS, SDG3) with the WHO, without a coordinated operational structure. There is substantial scope for developing synergies in subsequent phases, particularly in community governance, the continuum of maternal and neonatal care, vaccination coverage, and the functional link between basic services and hospital facilities.

D.4.1 What coordination mechanisms have been adopted with AICS Abidjan, the Italian Embassy in Brazzaville and the main international partners?

The evaluation team gathered information regarding the involvement of various stakeholders and the level of coordination in project management. This information was mostly gathered through meetings of the Steering Committee (COPIL), which were not particularly structured given the institutional complexity of the intervention. Other informal forms of interaction were reported, but their effectiveness and outcomes are difficult to ascertain.

The AICS office of reference was initially in Niamey, Niger, and only after the project's launch was responsibility transferred to the Abidjan office in Ivory Coast. While the Niamey office participated in the initiative's planning and ex-ante analysis, the AICS office in Abidjan's involvement consisted of field visits and participation in COPIL. This limited scope of intervention was defined based on the interpretation of the project's legal and financial nature, classified as a Budget Support initiative, despite the fact that it was actually implemented in a manner more akin to a traditional project. This ambiguity had a concrete impact on governance: technical and operational supervision was deemed not the responsibility of the AICS office, creating a functional limitation in ongoing monitoring of implementation.

The Italian Embassy in Brazzaville, for its part, ensured an extremely effective presence during the diplomatic phase, and facilitating communications between the parties. Given the lack of a permanent AICS presence in the country, the Embassy, despite its limited resources, ensured constant attention to the project. On the other hand, the lack of a dedicated technical structure within the Italian representation in Congo limited ongoing support for the intervention during the most critical phase: the start of construction and the delivery of biomedical equipment.

At the local level, the coordination mechanism between the various institutions involved has not always been effective. The Congolese Ministry of Cooperation (MCIPPPP), formally responsible for the project, involved the Minister of Health and Population only at the Cabinet level, leaving the role of the Ministry of Health's Technical Directorates and the Directors of the beneficiary hospitals themselves rather marginal, according to those interviewed. In some cases, these hospitals received equipment they were not informed about.

The most significant criticality that emerged from the interviews concerns the lack of systematic coordination with the main technical and financial partners active in the Congolese healthcare sector. Sources interviewed during the assessment mission confirmed that "the international partners were very surprised as it was the first time they had been involved," having previously received only fragmentary information, occasionally shared during an introductory meeting hosted by the Embassy or through the press during Italian institutional visits. The most significant case of lack of coordination concerns the World Bank, which expressed surprise at not being involved, "since it had also purchased materials for the same facilities," with a concrete risk of duplicating investment in the same hospital infrastructure.[13]Similar critical issues of lack of involvement are observed with regard to WHO and UNFPA, agencies which, according to the WHO-Congo Cooperation Strategy 2025-2028, share with Italian cooperation the same scope of intervention in Strategic Priority No. 3, dedicated to strengthening the provision of quality hospital care and services.

D.4.2 To what extent did Phase I of the Italian program fit coherently into the second phase of the WHO strategy for the revitalization of health districts?

[13]See the World Bank project: Projet de Renforcement du Système de Santé (KOBIKISA) https://projects.banquemondiale.org/fr/projects-operations/project-detail/P167890.The World Bank itself is planning a new project that will be launched soon in the country (see https://sante.gouv.cg/la-banque-mondiale-injectera-60-millions-de-dollars-dans-un-nouveau-programme-de-sante-publique-au-congo/)

As previously noted, the Italian intervention conducted at the tertiary hospital level is a complementary component to the WHO intervention focused on the revitalization of health districts. The WHO program is based on a minimum package of activities (MPA) provided to each Integrated Health Center (IHC), divided into five axes: supporting IHC teams in the provision of primary care (prevention, treatment, rehabilitation); strengthening the operational capacity of health facilities and teams; supporting community participation and local governance (through the Health Committees - COSA and Management Committees - COGES); and social mobilization through community associations and representatives. This is complemented by the WHO Emergency Obstetric Neonatal Care (EMONC) program, specifically dedicated to maternal and neonatal care.

The Congolese regulatory framework, defined by Presidential Decree No. 551 of October 15, 2020, defines the Health District as "a decentralized geographical, administrative, and operational entity under the responsibility of the local authority," characterized by four constituent properties: a population with defined responsibilities, defined geographical boundaries, two functional levels (primary care through CSIs and secondary care through district hospitals), and a functional management team based at the district hospital. According to this definition, the scope of the Health District ends at the second level (Hôpital de Référence de District - HRD) of the healthcare pyramid and does not structurally include the third level of General Hospitals, the primary target of the Italian intervention.

By 2024, before the start of the Italian intervention, the WHO programme had already produced measurable results: the strengthening of primary health care in twelve health districts, access to antenatal care provided by qualified personnel for 93% of pregnant women, and an improvement in preparedness and response to health emergencies.[14]These results confirm that, by the time the Italian project began, the process of revitalizing health districts was already a consolidated operational reality. The interview with the WHO Representative in Congo, conducted during the assessment mission, frames the revitalization of health districts as "a fundamental challenge for the Government of Congo and all its technical and financial partners in the health sector," defining it as "a guarantee for the provision of primary health care" and "the main foundation for achieving universal health coverage," in line with SDG 3 and the vision of the PNDS 2023-2026.

Phase I of the Italian program was therefore part of the same national programmatic framework as the WHO revitalization process, sharing its overarching strategic references (PNDS 2023-2026, CSU objectives, and SDG3), but did not translate into a coordinated operational structure. The lack of structured dialogue between the two interventions prevented capitalization on potential synergies, which were present and confirmed by the evidence collected. This evidence identifies four specific areas of potential synergy between the WHO program and the Italian intervention: strengthening governance through community participation bodies (COSA); improving the care delivery process, including greater use of partograms to reduce maternal and neonatal mortality and better management of medications and financial resources; improving vaccination coverage (Penta 1-2-3, measles, yellow fever) within the Expanded Programme on Immunization; and strengthening community involvement through the "community relay" mechanism.

4.3. Effectiveness

Q.5. To what extent have the 9 target hospital facilities been equipped with functioning biomedical technologies, with adequate infrastructure works and an operational EASI system?

[14]WHO Congo-Ministère de la Santé e de la Population. Revitalizes the health districts of Congo. 2024

- The planned supplies are largely complete: the final audit report and direct observation confirm the installation, technical verification, and inventory of technologies at the receiving units, including devices that were still uninstalled in the interim report. However, some limitations to full clinical operations remain, especially in intensive care units, due to the failure to complete or connect the oxygen and other medical fluid networks, which are the responsibility of the Congolese counterpart.
- The upgrades completed have enabled the establishment of technical laboratories and support spaces throughout the facilities. There are still opportunities to complete some locations and integrate the necessary additional infrastructure to fully leverage the technological investments made.
- The EASI system is formally active in the eight hospitals covered by the contract, with 5,969 devices registered and access assigned to the facility's focal points; however, its management still appears to be highly centralized within the private operator. Strengthening access, skills, and the involvement of hospital and ministry staff would be an important step towards consolidating its effective use and long-term sustainability.

D.5.1 What is the actual condition of the equipment planned for installation?

The analysis of the effectiveness of the supplied installations was conducted primarily on the basis of the findings of the final technical and financial audit report of the Auditec Foirier-KPMG group. This certified that, as of the date of the audit, the supplies provided were "consistent with the contractual schedule" and that the technologies provided "are installed at the destination operating units, subjected to technical verification, inventoried and registered in the management system. The document updates the critical issues that emerged in the Interim Report, where 45 devices were "shipped but not yet installed" and others were over 90% complete: as of the date of the final report, these 45 devices have been installed and put into operation with installation reports formalized and signed by the hospital managers. The overall census present in the Report lists 5,969 devices registered in the EASI system, including both the technologies provided by the program and the pre-existing ones taken over by the integrated management service.

The same Report, however, makes a significant technical distinction: for some equipment, full clinical operation remains conditional on the completion of work on the medical gas distribution network, which is defined as outside the contractual scope of the Public Service Delegation and therefore falls under the responsibility of the Congolese counterpart. The summary table for each facility shows that the intensive care units at the Makélékélé, Talangaï, and Adolphe Sicé hospitals have installed technology that is not fully operational due to the lack of oxygen connections, while the technical laboratory at Loandjili is still undergoing logistical completion, with service continuity being guaranteed in the meantime by the Adolphe Sicé hospital as the reference facility.

The AICS mission report of November 2-7, 2025, provided a detail that essentially confirms the audit's findings. At Dolisie, the lack of a medical oxygen production system was noted, which "significantly reduces the emergency service's response capacity." At Adolphe Sicé, the mission reported a scanner purchased in 2023 as part of the PRUC project (World Bank) "never installed to date" due to documentation issues, as well as a radiology building lacking the necessary radiation protection measures. At Loandjili, the faulty main elevator, which compromised the mobility of patients and equipment to upper wards, was highlighted as a critical issue, as was a centralized air conditioning system that was out of order. In Talangaï, the mission noted that the medical fluid circuit (oxygen, medical air, and nitrogen) was not yet connected to the fourteen newly installed bedheads, which limited the optimal use of the department. In Makélékélé, the medical fluid circuits in the Neonatology ward were similarly in need of updating. The report concluded that, according to statements from the company Althea EM, the contractually agreed-upon equipment "has been installed at 95%," with the sole exceptions of the UPS electrical protection devices and some pediatric ophthalmology and anesthesia equipment, which had already arrived but were awaiting customs clearance.

The COPIL meeting of November 18, 2025, officially recorded the findings of the AICS mission. The remaining "physiological" critical issues were reported there, primarily the need to intervene on the medical flow systems, specifying however that such interventions were not within the scope of the private contractor's remit. The COPIL meeting of February 25, 2026, confirmed the persistence of the problem, noting "the urgency related to certain critical issues already reported... particularly regarding the oxygen circuits in the emergency resuscitation rooms built, which have not yet been connected" and formally acknowledging "delays in the actual commissioning of some equipment." The assessment, while confirming the completion of the scheduled supplies, ultimately highlights as a critical issue the limitations already highlighted in the design and selection of the equipment, the acquisition of which was not accompanied by adequate verification of the completion of all ancillary infrastructure. These, although outside the scope of the PSD agreement, should nevertheless have been included in the design process to ensure effective and optimal use of the acquired equipment.

Q.5.2 Is the EASI traceability system operational in all facilities or only in some?

The final technical and financial audit report describes EASI as the central support element for the integrated management of biomedical equipment support and maintenance services. The facility-by-facility summary table shows that the EASI system is reported as active for all hospitals within the scope of the contract (Blanche Gomes, Makélékélé, Talangaï, Adolphe Sicé, Loandjili, Dolisie, Owando, and Oyo). The only exception is the CNTS (National Blood Transfusion Center): given the limited size of its technology pool and the lack of suitable facilities, technical management and traceability have been entrusted to the laboratory and system of the Blanche Gomes Maternity and Children's Hospital. The document also states that "the access credentials to the IT system have been formally assigned to the technical focal points identified within each healthcare facility" and that "dedicated access has also been granted to the focal point designated by the Ministry of Health," with separate consultation, data entry, and technical validation profiles.

In practice, however, both the successive AICS missions and the evaluation mission itself revealed a slightly different and more problematic picture than the audit's documentary description. In terms of the operational management of the traceability system, the AICS missions describe a centralized intervention management system, entirely built and administered by the private operator, which plans maintenance, records faults, and monitors their resolution through a unique inventory code for each piece of equipment. Meanwhile, local hospital staff are still marginalized in its actual management, with limited access to the underlying technical documentation. In this regard, the November 2025 mission recommended promptly identifying the technicians already employed in each beneficiary hospital and drawing up a national map of biomedical skills, to "ensure the continuity of technical service within the facilities and avoid exclusive dependence on external providers." Furthermore, during the final evaluation mission, access to the EASI IT system to verify its quality and effectiveness was not granted. The evaluators therefore had no clear confirmation of the audit report's conclusions, even though in this case this was a key element for the project's success, which should allow for coordinated management of resources and equipment procurement.

D.5.3 Have the local technical laboratories and call centers been activated as foreseen in the plan?

The final audit report confirms that "The technical laboratories have been set up and are operational, with assigned staff and activities regularly recorded in the management system"[15]. A different solution was adopted for the CNTS, and technical coverage is provided by the laboratory of the

[15]Groupement AUDITEC-FOIRIER CONSULTING & KPMG CONGO. Relationship Technique and Financier Final du financement octroyé par la République Italianenne à la République du Congo pour le reinforcement de sonté offers de santé. Mars 2026

Blanche Gomes Maternity and Children's Hospital. For the Loandjili General Hospital, however, "The local technical laboratory is not yet fully operational from a logistical and organizational point of view", with maintenance activities being ensured in the meantime by the technical laboratory of the Adolphe Sicé Hospital as the reference structure, with no interruptions in service detected.

Regarding technical call centers, this component is included among the technical and logistical support systems envisaged by the project, along with the technical laboratory and the EASI IT system, described as structures supporting direct communication between clinical staff and maintenance technicians. The detailed audits conducted for each hospital in the Interim Audit Report confirm the activation of call centers, alongside technical laboratories and equipment inventory, for the facilities visited. Neither the Interim nor the Final Reports revealed any reports of call centers not being activated in the facilities covered by the contract.

The assessment mission verified the effective functionality of the facilities set up, both with regard to the technical laboratories and the call centers for managing maintenance needs. The spaces made available within the hospital facilities have all been renovated by the private operator, which covered the related costs. The laboratories are currently equipped and regularly supplied with the main components for the maintenance of biomedical equipment. Furthermore, the laboratory personnel are almost entirely at the exclusive disposal of the private operator: they are Italian technicians with expertise in biomedical supplies or young local technicians undergoing training. No mechanism appears to have been included at the project level to ensure the subsequent transfer of this personnel (at least the local ones) within the hospital facilities, raising substantial questions about the sustainability of the actions undertaken.

Confirmation of this project challenge was found in interviews with Ministry of Health officials, who highlighted the need to integrate the activities carried out by the Italian project with the Ministry's training and maintenance system, in order to have positive impacts on the entire healthcare system. This system, limited as it is, continues to manage the country's hospitals through the availability of limited centrally managed human resources, who could benefit from the project's activities. However, the maintenance and training system managed by the private operator (EASI platform, dedicated technicians, and hospital technical laboratory) operates as a parallel infrastructure, not integrated with the ministerial technical management.

Q.6. To what extent have trained healthcare and technical personnel acquired effective skills in the use, management, and maintenance of biomedical technologies?

- The project has launched training and on-the-job coaching activities aimed at the use, maintenance, and repair of biomedical technologies; however, achieving the target of 75% improved staff skills is unverifiable, as neither the initial assessment required to define the targets nor the post-training tests needed to measure progress have been developed.
- Qualitative evidence indicates an ongoing transfer of skills, supported by collaboration between hospital technicians and private operator staff, which is appreciated by facility managers. However, maintenance work remains predominantly performed by external technicians, and the actual implementation period does not yet allow for an adequate assessment of the level of autonomy acquired by local staff.
- On-the-job mentoring provides a positive foundation for developing local capacity, but has yet to produce a structured "train-the-trainer" mechanism capable of fostering the dissemination of expertise within the Congolese health system. Transforming this best practice into a multiplier would require the institutionalization of a dedicated training program, advocated by many stakeholders but not yet implemented, and greater coordination with partners such as UNESCO and the WHO.

D.6.1 Has the target of 75% of staff with improved skills been achieved not only in quantitative terms (% trained) but also in qualitative terms (quality of transfer)?

The Logical Framework of the Evaluation Form attached to the project established indicator I.3.1 as "% of healthcare technical personnel improving their skills in equipment use and maintenance following training," with a target of 75%, to be measured through "post-training assessment tests." The project document itself postponed the definition of these values to a later date, noting that the baseline had not been defined at the time of approval. The expected initial assessment report with baseline values does not appear to have been prepared, nor is there evidence of the results of the post-training assessment tests intended as a source of verification. The target of 75% of personnel with improved skills is therefore not verifiable either quantitatively or qualitatively based on the evidence collected, while the limited evidence available suggests that the transfer of skills is still partial and unconsolidated.

Interviews conducted at beneficiary hospitals indicate that maintenance, although present in all facilities, is almost always performed by the private operator's staff and rarely by specialized hospital technicians. The director of Talangaï Hospital, describing the relationship with the contractor's technicians, reports that the hospital and Althea EM staff "form a single maintenance team" that "works jointly by exchanging experiences," but acknowledges that technical interventions remain conducted by external personnel, albeit physically based on-site. Althea EM staff themselves confirmed that biomedical technicians were trained in Congo as part of the installation of hospital technical laboratories, without providing evidence of levels of autonomy achieved or formal learning assessments. Qualitatively, interviewees positively acknowledge the technical and human skills of Althea EM staff present in the field, without, however, constituting a judgment on the value of the effective transfer of skills to local staff.

It should also be noted that the project design limited the scope of training to the technical use of the equipment and its maintenance or repair, excluding any clinical training component geared toward diagnosis and treatment. This means that, in any case, the training target concerns a specific skill and not the full range of professional skills of the healthcare personnel involved. A final consideration concerns the implementation timeline, which was more compressed than in the original project design: all the operators involved confirmed that the supply and related activities, including training, were completed in a shorter period than expected (within an actual operational timeframe of approximately six months), as the timeframes specified in the contractual agreements were considered a maximum limit and not an operational constraint. This significantly reduced the possibility of assessing a true consolidation of technical skills: the transfer of know-how from an expert external operator to local staff is a process that requires mentoring, supervised practice, and progressive assessment of the achieved autonomy, which is difficult to measure within a few months of the actual start of operations. Most of the hospital directors interviewed, regarding a comparative assessment of the pre- and post-intervention situation, agreed that these were "merely indications," specifying that it was too early to assess their impact. This statement, referring more generally to the project's impact, also applies to the specific issue of skill transfer, which by its nature requires longitudinal observation to be assessed in terms of solidity and autonomy achieved, and not just by formally passing post-training tests.

D.6.2 Has the training model generated the ability to "train the trainers" (internal multiplier)?

The training model adopted by the project has not yet generated a structured capacity for "training the trainers": it has instead been a matter of operational "on-the-job" support, which constitutes good

practice but has not been institutionalized in a formal program capable of independently multiplying skills within the Congolese healthcare system.

The training component of the Italian intervention primarily targeted hospital machinery maintenance personnel and equipment assembly experts. The goal was to prevent equipment supplied by the project and other stakeholders from sitting in packaging or hospital warehouses for years, or to prevent personnel from being able to repair or replace a damaged component. The solution implemented consisted of creating a team of maintenance personnel within the hospital, supported and trained "on the job" by the Italian team. This is considered a good practice, and the intervention is effectively implementing it, but it remains anchored to the direct transfer of knowledge between trainers and trainees within the Althea EM technician/hospital technician team, without an explicit plan to train professionals capable of training new personnel—that is, a true multiplier mechanism. Interviews conducted at Talangaï Hospital confirm this approach: local technicians and those from Althea EM "form a single maintenance team," but the goal stated at the start of the project, "that there be a progressive transfer of skills," is still an ongoing process, not a consolidated result that can be transferred to other operators in the same hospital or other facilities.

During the meeting for the medium-term review of hospital activities, held in Brazzaville in July 2026, the UN Resident Coordinator expressed the hope that the practice of working alongside Italian technicians and local staff will be extended over time, proposing the establishment of a structured professional training course for maintenance workers.[16]. The availability of a ten-year agreement between UNESCO and ENI on professional training in Congo has also been reported, which could be involved in providing a permanent structure to this process. These signs indicate that, at the system level, the potential value of the model adopted by the Italian project is recognized, but also its current lack of formalization and capacity for self-replication. The same mid-term review of hospital activities also found that the human resources of the Congolese healthcare system suffer from a quantitative and qualitative deficit of specialized personnel, without a national continuing training plan, a staff retention policy, and a dedicated collective bargaining agreement. This context in itself limits the ability of the Italian mentoring model to generate stable internal trainers, in the absence of a public skills management policy within which to integrate. The recommendations that emerged from the same review, addressed to technical and financial partners, explicitly call for contributing to the strengthening of biomedical maintenance through the training of engineers and technicians, and for establishing a mentoring and coaching system among hospitals, confirming that a real multiplier mechanism (training of trainers, peer mentoring, structured coaching) still needs to be built.

The Italian project does not have the tools (structured curriculum, certification, dedicated local teachers) to generate internal multipliers, and this function should be developed through external partnerships, particularly with the WHO for the supply of equipment and UNESCO, together with a local training body, for the institutionalization of maintenance training. A complementary element of analysis of the adopted training model concerns the supply chain: even if autonomous local maintenance workers capable of training colleagues were trained, their ability to operate independently would be contingent on the availability of a supply chain, which the project has not yet organized, as a list of useful supplier contacts has not yet been shared. Finally, as noted above, the training provided by the Italian project remains limited to the use of equipment, excluding broader components such as diagnosis or clinical teaching, which would be necessary to develop true teaching transfer skills.

[16]Ministère de la Santé et de la Population. Direction Générale des Soins et Services de Santé. Revue à Mi-Parcours des Activités des Hôpitaux. 2026

4.4. Efficiency

Q.7. To what extent has the Sector Budget Support mechanism functioned as a policy dialogue tool, guiding the Congolese government's choices towards measurable health outcomes beyond simple documentary compliance?

- The Sector Budget Support mechanism defined the reporting framework: the conditions for disbursement of the second tranche (at least 50% of the first tranche spent and 70% committed) were met, helping to accelerate supply and installation times. However, these conditionalities were primarily focused on financial absorption and contractual compliance, without indicators related to service quality, sustainability, or strengthening the health system's capacity.
- Bilateral dialogue has fostered the initiative's overall alignment with the PNDS and strengthened the visibility and relational capital between Italy and Congo, including through high-level political meetings. It has strengthened the program's political priority and the impetus to continue it toward Phase II, while its ability to influence operational decisions regarding resource allocation has remained rather limited, apparently due to the SBS's ownership logic and the broad autonomy maintained by Congolese institutions, particularly the MCIPPPP.
- Overall, financial management is traceable, with accounting separation between the €35 million in aid credit and the €10 million in grants, and no discrepancies noted in the reconciliation of flows. However, the PSD's flat-rate remuneration model did not allow for a precise distinction between the resources allocated to technology, maintenance, and training, limiting the ability to measure and report the health and capacity-building results achieved by the various funding components.

D.7.1 Did the Agreement's conditionalities (Articles 5.3 and 5.4: >50% spent and >70% committed for the second tranche) have an additional effect on the quality of implementation?

The Bilateral Financing Agreement established a disbursement divided into two tranches and specific conditionalities for the disbursement of the second tranche of the concessional loan, amounting to €15 million. This was to be released "following the approval by the Steering Committee... of a technical and financial report from the auditing firm... certifying that at least 50% of the first tranche has been disbursed and that at least 70% of the first tranche has been formally committed through orders, contracts, or agreements." The formulation of this conditionality was therefore purely quantitative and financial, measuring only the speed of absorption of funds and the level of contractual commitment, not the technical quality of the projects, their consistency with healthcare needs, nor did it include indicators of institutional strengthening of the Ministry of Health or the healthcare system as a whole. The technical-financial report required by Article 6.1.5 of the Agreement was to exclusively cover "the full amount committed and disbursed" and contain "a report on the contracts carried out," confirming that the focus remained on compliance and the adequacy of spending rather than the effectiveness of the intervention. Its analysis focuses on comparing unit costs per bed with relevant international benchmarks, providing a check on economic appropriateness, and does not support a conditionality mechanism linked to health outcomes or capacity building.

The practical implementation of the bilateral agreements has effectively created time pressure on execution. The COPIL of December 22, 2025, certified that, for the purposes of releasing the second tranche, the audit firm had certified the actual expenditure of more than 50% of the first tranche and

that more than 70% of the first tranche had already been committed. These conditions were deemed sufficient to satisfy the requirements for requesting the disbursement of the second tranche. However, it did not mention the difference in execution timelines from those envisaged in the documents approved for the initiative's financing. The AICS Mission Report of November 2025, in fact, noted "the surprising speed of implementation of the project (3 months from the crediting of the financing tranches to the Ministry of Cooperation)," attributing this to the logistical capacity of the operator Althea EM, which "maximized its logistical capabilities" precisely in view of these deadlines. This finding suggests that conditionality did indeed accelerate the physical delivery of equipment, but as a side effect of a financial reporting logic, not as a mechanism explicitly designed to raise the quality standards of the intervention.

None of the documents examined indicate that the 50%/70% thresholds were accompanied by parallel indicators of technical quality, sustainability, or national capacity development. Indeed, the COPIL of February 25, 2026, clarifies the limited role of the Italian side in this framework: "Since this is budget support, AICS does not intervene by applying traditional methodology or operating methods, ... therefore, it is not within AICS's remit to go into the details of the contracts" between the Congolese government and the private operator, whose compliance verification has been delegated exclusively to the audit firm. This arrangement confirms that the Agreement's conditionality mechanism focused on certifying the use of funds (exceeding spending/commitment thresholds, separation of credit/grant accounts) rather than on targets for strengthening Congolese health governance. This aspect, however, was deferred at the same meeting to a future "technical monitoring committee" yet to be established.

The overall analysis suggests that the Agreement's conditionalities had an additional effect primarily on the speed of implementation and financial reporting discipline, indirectly contributing to the rapidity with which equipment was supplied and installed. However, the lack of conditionality indicators linked to parameters of technical quality, institutional sustainability, or capacity building at the Ministry of Health represents a structural limitation of the budget support instrument's design: the 50%/70% threshold logic remains focused on fund absorption, while improving the country's sector development capacity is delegated to complementary and informal tools, such as the recommendations emerging from monitoring missions and the proposal, however unimplemented, for a technical committee dedicated to impact monitoring and planning the program's second phase.

D.7.2 Did the bilateral political dialogue impact the allocation decisions of the MCIPPPP and the MSP?

International guidelines on BS define policy dialogue as "one of the main components of budget support contracts, together with the transfer of funds, performance evaluation and capacity development"[17]. Effective dialogue is typically characterized by a "government-led, proactive, strategic, structured, and documented" approach[18], based on monitoring data ideally generated by the recipient itself. The literature on Sector Budget Support, on the other hand, is explicit on a crucial point: "Donors have limited influence on high-level policy decisions. This influence declines over time just as domestic ownership of policy strengthens"[19]. Donors are therefore recommended to "focus on supporting policy implementation rather than influencing high-level political decisions," and it is empirically observed that SBS "tends to be allocated as an additional resource to sector spending" without donor additionality requirements "making a major difference to the overall trajectory of sector resource allocation"[20].

[17]Budget Support Guidelines, European Commission / International Partnerships (2017)
[18]ibidem
[19]Sector Budget Support in Practice: Good Practice Note, ODI (Overseas Development Institute) - 2010
[20]ibidem

The case under evaluation fully confirms this theoretical framework, and in some respects radicalizes it. The bilateral dialogue has produced tangible results in terms of theoretical strategic direction, with the Project Document constructed in full coherence with the 2023-2026 National Development Plan (PNDS) and the direct involvement of political leaders at the highest levels. However, when it comes to operational allocation decisions, the documentary evidence reveals a picture of almost complete Congolese autonomy, amplified by the choice of the implementation instrument (the Public Service Delegation). Consistent with the literature's observation of the "additional" but not transformative nature of the SBS, in the Congolese case too, the Italian contribution appears to be an injection of additional resources into a sectoral governance that the bilateral dialogue has not been able to profoundly reshape. The same AICS mission report from November 2025 noted, at each hospital visit, "an insufficient level of information about the initiative" and "difficulties relating to intra-Congolese institutional communications," recommending greater coordination between the Ministry of Cooperation, the Ministry of Health, and hospital management for the second phase, precisely because such coordination had not occurred spontaneously in the first phase.

The Italian ministerial mission of January 9, 2026, which included meetings with President Sassou-Nguesso, Prime Minister Collinet Makosso, and the Congolese Ministers of Cooperation and Health, was described as a positive development in bilateral relations, contributing to the intervention's political and institutional visibility. Indeed, the political dialogue served primarily as a legitimizing factor, accelerating the Congolese request for Phase II, already formally submitted to the MCIPPPP prior to the mission, rather than as a tool to redirect specific allocation decisions by the Ministry of Health. The Italian political dialogue thus generated visibility and mutual trust, but did not translate this relational leverage into effective co-decision on resource allocation priorities, which remained essentially the prerogative of the Congolese MCIPPPP, resulting in internal fragmentation that reverberated down to the level of individual hospital directorates.

D.7.3 Were the SBS funds managed in a transparent, traceable manner and with accounting separation between the two components?

The analysis of the Final Technical and Financial Audit Report confirms the assessment of transparency, traceability, and accounting separation already formulated in the Interim Report, but allows for a clearer definition of the audit's methodological limitations, which the document itself explicitly states.

Chapter 7 certifies that the cash flow analysis covers the concessional credit component (€35 million) and the grant component (€10 million) separately, with the two items recorded separately within the tranches received (€45 million in total). The end-to-end reconciliation of disbursements, bank records, transfers to the private operator, and reference invoices revealed no unexplained discrepancies or discrepancies, confirming the full traceability of the financial chain up to the operational beneficiary.

Paragraph 7.1 (Methodological Preamble) introduces an explicit and relevant limitation with respect to the Interim Report: while the latter had conducted "an in-depth analysis of the consistency between contractual conditions and applied prices," the Final Report states that it focuses "exclusively on the traceability of financial flows, the correspondence between contributions received and amounts transferred, as well as the financial coverage of activities in the first contractual year." It is important to underline that the interim audit report was in fact conducted around three axes: the correspondence between planned and implemented activities, compliance with the operational schedule, and the consistency of committed expenditure, the latter understood as a qualitative analysis of unit costs compared to market prices (for example, the comparison of the maintenance rate of biomedical equipment, estimated between 12% and 15%). In that case, therefore, it was a primarily physical-technical audit (equipment inventory, delivery and installation status, price appropriateness) and not an accounting-financial audit of the cash flows themselves, nor a

verification of their actual recording in the balance sheet or the separation of accounts between the components. Therefore, between the two reports, the scope of analysis was progressively narrowed: from a verification of the economic appropriateness of the prices (Interim Report) to a verification of the formal consistency of the flows (Final Report), assuming that the appropriateness was already established.

This discrepancy is made even more explicit in paragraph 7.5, which states that, "taking into account the nature of the Public Service Delegation contract, structured according to predetermined contractual amounts and not according to a logic of analytical reimbursement of individual costs incurred," no element emerged "of such a nature as to alter the conclusions already formulated in the Interim Report regarding the justification for the overall amount relating to the first contractual year." In other words, the Final Report simply recalled the conclusions already formulated in the intermediate phase, assuming them as valid without further investigation.

The document itself describes its outcome as a "reasonable level of assurance… within the limits of the available evidence and the scope of the mission" (section 3), not as a certification of absolute correctness. The audit of payments made by the operator to suppliers was conducted "on a sample basis" (section 7.3), and therefore is not exhaustive. Furthermore, the methodological note on the "% of goods and services of Italian origin" column clarifies that the figure indicated refers solely to the contractual counterparty receiving the disbursements (the Italian-registered company Althea Emerging Markets) and does not constitute "an analytical reconstruction of the actual geographical origin of each good, component, service, or input used in the execution of the Program."

Regarding the allocation of the funds, based on their different types of grant and soft loan, it should be noted that the Italian contribution of €45 million was disbursed with the specification that the two components of the financing would contribute synergistically and complementarily to the achievement of the program's objectives, but without any indication of the specific destination of the funds. This allowed for financial management that made no distinction during implementation regarding which portion of the financing was actually allocated to the training/capacity building component versus the technology supply or maintenance component.

The Public Service Delegation itself is configured as a contract "aimed at achieving a result" and not as a supply of goods and services broken down by cost item. Therefore, "a total annual lump sum will be paid upon the achievement of all the expected results" and it is not possible to "break down the cost items in greater detail" than the macro-activities of the timetable. As a result, the lump sum payment cumulatively covered supply, maintenance, and training activities without a direct accounting link to the funding source (credit or grant). This effectively made it impossible to isolate and assess the specific impact of the grant component on capacity building in reporting, despite the latter being the component conceptually most consistent with the nature of the grant itself. This also limited the Italian Cooperation's ability to specifically report on the results achieved using non-reimbursable funds.

Q.8 Did the management, supervision and procurement mechanisms respect the principles of cost-effectiveness, transparency and respect for deadlines?

- The management mechanisms enabled the rapid completion of scheduled supplies and the start of maintenance: by March 2026, 1,464 maintenance interventions had been recorded, of which 93% of blocking failures were resolved within 24 hours. The audit also revealed consistency between completed activities, financial flows, and operational planning for the first year of the Work Plan, providing a basis for transparency and traceability of execution.

- COPIL performed an active oversight function, providing timely technical observations on critical issues that emerged during implementation. However, its ability to systematically monitor results, deviations, and corrective actions was hampered by the lack of a single, fully usable indicator framework. The failure to define the required baselines and the discrepancies between indicators in the project documents limited COPIL's ability to objectively verify project progress. This resulted in oversight primarily based on qualitative evidence, audit reports, and specific notifications, rather than on a shared performance system directly linked to corrective decisions.
- The supply chain progressed within the timeframe established in the first-year Work Plan, completing the installations and residual elements highlighted in the interim report by March 2026. However, there remains a misalignment between this annual plan and the three- or five-year timeframe envisaged in the various project documents, which has negatively impacted the ability to assess the other project components: maintenance and training should have been spread out over a longer timeframe to fully appreciate their benefits and actual positive impacts.

Q.8.1 Did COPIL exercise an effective supervisory role or did it remain a predominantly formal body?

The program was governed by a joint Italian-Congolese Steering Committee (COPIL), which met every six months and was responsible for validating monitoring reports and verifying the progress of activities. The COPIL was composed of a representative from the MCIPPPP, a representative from the MSP, a representative from the Italian Embassy in Brazzaville, and a representative from the relevant AICS Foreign Office. The Monitoring, Evaluation, Research, and Learning (MERL) system included:

- Half-yearly monitoring reports produced by the technical departments of the relevant ministries, in particular by the MSP's DG Equipment;
- An intermediate (mid-term) evaluation with an early warning function and the issuing of corrective measures;
- A final evaluation within 90 days of closing of activities.

Before analyzing COPIL's work, it's interesting to consider the primary tool this body should have used: the performance indicator framework. Unfortunately, these indicators are difficult to identify, as they are reported in rather different ways in the project documents. Below is a table comparing the three main reference documents: the Project Document prepared by MCIPPPP, the Evaluation Form prepared by AICS and submitted to the Joint Committee, and the Operational Work Plan drawn up by the operator Althea EM, which should reflect the contractual commitments made at the PSD.

Table 6: Comparison of indicators and reference documents

Size	Project Document	Evaluation Form	Work Plan
Presence of a structured logical framework	Yes, but simplified: a 4-level table (general objective, specific objectives, result, indicators, activities) without baseline/target columns	Yes, complete logical framework with columns Intervention logic / Indicators / Baseline / Target / Verification sources / Hypotheses	Absent: the document does not contain any logical framework or list of performance indicators
Reference level of indicators	National/District Health System (consistent with the PNDS system, "Nombre de districts revitalisés")	Dual level: general objective on national epidemiological indicators (maternal mortality, life expectancy) and results (R1-R3) on target structures	The 9 target hospitals, but only at the level of internal clinical areas, without explicit connection either to the national targets or to the contractual KPIs
Equipment availability indicators	"Disponibilité des équipements médicaux", "Nombre d'appareils médicaux fonctionnels" —	Equipment availability (Uptime): baseline TBD, target 96% on a quarterly	Not present as an indicator; the document only describes the current state

Size	Project Document	Evaluation Form	Work Plan
	descriptive indicators, without numerical thresholds	basis; Utilization rate: target 80% on a quarterly basis	of equipment hospital by hospital in qualitative form
Maintenance indicators	Listed as separate and parallel "KPIs" to the logical framework: uptime 96%, 24/48h intervention time, complete inventory within 6 months — but without being integrated into the logical framework table itself	Functioning technical bases/coordination centers (target TBD); scheduled maintenance schedule (target: 1 per facility); fault response time (24/48 hours)	Not quantified: it is mentioned that the PSD provides for "specific performance indicators" linked to contractual penalties, but without reporting the list or the values
Training indicators	"Nombre d'agents de santé formés", "Niveau de connaissances des agents de santé" — quantitative indicators, without targets	Healthcare personnel improving skills: baseline TBD, target 75%	Not present; training is described as an operational activity (staff training plans) without outcome indicators
Infrastructure indicators	"Improvement of health infrastructures" (activity item, not measurable indicator)	% improvement in infrastructure and performance: baseline TBD, target +40%	Not present; only qualitative description by clinical area (surgery, emergencies, etc.) of the deficiencies found hospital by hospital

Source: Evaluation Team Processing

The most significant discrepancy is that only the Evaluation Form developed by AICS has a truly structured logical framework, with quantified baselines and targets for each outcome (96% uptime, 80% utilization, 75% trained personnel, 40% infrastructure improvement, 24/48-hour response times). On the other hand, the same Form refers to the definition of target values by quantifying the initial values through an "initial assessment report" to be produced later, which, however, was never actually prepared. The Project Document prepared by the Congolese counterpart, which is the upstream document, instead contains a table of generic and non-quantified indicators, borrowed from the PNDS system logic, and accompanied by a separate list of contractual "KPIs" that only partially overlaps with the simplified logical framework, generating an inconsistent duplication between the two levels within the same document. Finally, the Plan de Travail, despite being the most operational document and closest to the executive phase, does not contain any result indicators: it is limited to a timetable of activities and a spending plan for each hospital, mentioning only generically the existence of "specific performance indicators" linked to contractual penalty mechanisms in the PSD, without ever reporting the list or the target values.

The result was a cascading misalignment, which complicated the evaluator's analysis and further complicated the work of COPIL: the more rigorous logical framework (AICS Form) was not explicitly anchored in the document that should have guided the project's practical implementation (Travail Plan), making it difficult to reconstruct a coherent monitoring chain between strategic planning and operational planning. At its first meeting (June 9, 2025), COPIL did indeed validate the Travail Plan, but failed to identify discrepancies with other documents regarding useful monitoring guidance. A reading of the minutes of the Steering Committee (COPIL) meetings reveals the work of a body that provided high-quality and increasingly explicit technical clarifications, but with insufficient capacity to influence the effective implementation of corrective requests, even with respect to its own findings.

The first COPIL (June 2025) actually formulated specific operational recommendations: separation of credit/donation accounts, the need for parallel infrastructure upgrades (hydro-energy efficiency) to ensure the equipment's operation, and the opportunity to focus the first phase on a limited number of facilities rather than the total nine. The second COPIL (November 2025) was even more detailed, identifying six specific critical issues: connecting oxygen circuits in resuscitation rooms, access routes to new services (hygiene, air conditioning, Loandjili elevator), recovery of inventoried equipment, reactivation of two scanners donated by the World Bank but left unused, identification of

users requiring training, and organization of spare parts procurement. It also noted that hospital management had not been sufficiently informed about the project's details. The fourth COPIL (February 2026), explicitly dedicated to the follow-up to the previous Committee's recommendations, constituted the most significant test of the instrument's effectiveness, as it noted that previous concerns remained unresolved and that delays in the actual commissioning of some equipment were compromising its full functionality. Along with the need for strengthened coordination, these issues represented similar problems to those already reported three months earlier and still unresolved.

Despite these limitations, COPIL has played a positive institutional role: it formally validated the audit contract and the related report. At its February 2026 meeting, the Committee openly acknowledged its oversight limitations, calling for new control tools rather than an immediate resolution of the critical issues. However, even in this case, the decision to establish a technical monitoring committee dedicated to analyzing health data and the intervention's impact remained largely unimplemented. COPIL therefore does not appear to be a purely formal body, as its clarifications are operational, detailed, and repeated over time. However, its effectiveness as an effective oversight body has been limited by the lack of tools for verification and implementation of the desired corrections.

D.8.2. Were the approved schedule deadlines respected?

Compliance with the implementation schedule must be interpreted on two distinct levels, which must not be confused: the internal consistency of the Work Plan (which only covered the first year of a three-year project) and the structural deviation from the timeline of the project document originally submitted by the Congolese counterpart, which was drafted for a five-year duration. The Work Plan explicitly clarifies that the original project, as communicated by the Congolese Ministry in June 2024, envisaged a five-year duration for a total cost of €238 million, while the Italian contribution, ratified in September 2024, concerns €45 million as an "initial tranche," with Italy's commitment to finance subsequent phases only after the first is completed. The operational Work Plan, therefore, does not reflect either the original five-year timetable or the three-year project document developed in the AICS Evaluation Form, but focuses on the operational details of a single year of implementation, compared to a total duration of 36 months.

This led to an implicit redefinition of the timeframe, never openly discussed between the parties: from a project conceived as a continuous five-year process, the project shifted to a contractual framework (PSD) segmented into separate phases. The first phase was actually the subject of Italian funding, while subsequent phases would be formally requested by the Congolese government and subsequently approved by the Italian government. This phased architecture created an inherent risk of disruption between one cycle and the next, and unsustainable expectations regarding timing on the part of the Congolese side, which submitted its request for Phase II funding to COPIL well before the expiration of the first contractual cycle.

Within the framework of the Work Plan, documentary evidence demonstrates the aforementioned rapid progress in implementation. The interim audit report of December 2025, covering the first 19 weeks of the project, recorded 45 devices classified as shipped but not yet installed, installations over 90% complete but with residual accessory elements, and training activities and technical receptions still being finalized, all aspects resolved upon submission of the final report (March 2026). In terms of maintenance, the system has moved from a start-up phase (November 2025) to a consolidated regime, with 1,464 interventions recorded as of March 2026, of which 1,322 were preventative and 142 corrective, and response times for blocking faults met within 24 hours in 93% of cases.

However, if these implementation elements are compared to the three-year Operational Plan and the results envisaged in the Evaluation Form underlying the intervention's approval, the situation appears rather different. In particular, it is difficult to positively evaluate the compression of maintenance and training activities on the supplied equipment, conceived on a three-year basis, into

a limited period of just a few months of actual operation. While the equipment supply component could legitimately have been completed in a shortened timeframe, thanks to the planning and logistics capabilities implemented within the PSD, the other two components of the tripartite program (training and maintenance) should have been spread over a longer timeframe to appreciate their benefits and actual positive impact on the national health system's capacity.

4.5. Impact

Q.9. What significant effects—both expected and unexpected—has the program had on the Congolese health system's capacity to provide advanced diagnostic and therapeutic services?

- The program has resulted in an initial strengthening of the diagnostic, surgical, and emergency care capacity of the nine targeted facilities, making more advanced technologies and services available and contributing to improved emergency room, operating room, and diagnostic services. However, it is still premature to assess an actual reduction in medical evacuations or migration for treatment abroad: the intervention impacts the availability of technologies, but significant factors persist, such as infrastructure deficiencies, drug availability, specialized clinical expertise, safety of care, and population trust in local services.
- The impact on the healthcare system remains limited to the nine beneficiary facilities, with no structured mechanisms for dissemination to other hospitals. However, there are concrete opportunities to expand its impact by integrating the maintenance and training model with the Ministry of Health system, promoting exchanges between hospitals, and leveraging equipment purchased from other donors that has not yet been installed or maintained.

Q. 9.1 To what extent did the intervention contribute to reducing the use of foreign facilities or healthcare migration for services not available locally?

Medical evacuations from the Republic of Congo to countries with more advanced medical infrastructures, generally France or South Africa, are organised via medical aircraft due to the complexity of the cases treated, and for state officials there is a circular from the Ministry of Finance which defines the maximum amounts, applicable exclusively for treatments not available in the country.[21] Beyond this institutional channel, medical migration also involves Congolese middle- and upper-middle-class citizens seeking less critical procedures, such as dental and cosmetic treatments, to destinations like Turkey or Morocco, as well as for serious conditions like cancer or cardiovascular rehabilitation. Alternatively, teams of foreign specialists are sometimes called upon to work locally on a one-off basis.

The Italian intervention is contributing to making diagnostic techniques more sophisticated, as well as emergency rooms and operating rooms, making them better equipped and functioning. This improvement is consistent with the program's overall objective of contributing to the expansion of access to and coverage of quality healthcare services in Congo's public hospitals. However, it is still premature to observe a tangible improvement in terms of reducing healthcare migration: greater effectiveness would primarily require a major information campaign, as currently there is no visibility on the new services available, not even at the district level for potential referral of the most seriously ill patients to rehabilitated facilities. Available performance data confirms that the supported facilities are showing significant activity volumes (for example, the Hôpital Général Adolphe Sicé recorded over 25,000 external consultations and more than 3,500 surgical procedures in 2025, with a bed

[21] https://www.finances.gouv.cg/sites/default/files/documents/Circulaire%20%C3%A9vacuations%20sanitaires.pdf

occupancy rate increasing from 59% to 67%), but these data reflect the facilities' ordinary activity and do not allow us to isolate a specific effect in reducing healthcare migration.

The mid-term review of Congo's hospital operations has also identified a series of critical issues that persist despite Italy's intervention and continue to impact the need to seek treatment abroad. These include poor infrastructure, limited training for medical staff, and poor drug availability. Regarding the quality and safety of care, the review recommends developing standardized protocols for the prevention of nosocomial infections, making blood transfusion centers operational in all referral hospitals, and establishing infection prevention and control programs. It notes that the level of clinical safety in local facilities remains a factor that discourages the trust of wealthier patients and pushes them to seek treatment abroad. Regarding infrastructure, it recommends prioritizing preventive maintenance of critical equipment and establishing an investment plan to modernize operating rooms and laboratories. Regarding patient management, it highlights the need to strengthen the referral and counter-referral system and conduct satisfaction surveys to adapt services to the population's actual needs.

Several recommendations emerging from the mid-term review are directly instrumental in reducing the use of foreign facilities or occasional providers: developing communication plans to raise public awareness of the services actually available, integrating national priorities related to the acceleration project promoted by the Head of State, and supporting the accelerated implementation of the Caisse d'Assurance Maladie Universelle (CAMU) in public and private healthcare facilities, which impacts the economic sustainability of access to local care compared to the option of evacuation abroad. On the human resources front, the review recommends developing an institutional mentoring program between hospitals and continuing education programs aimed at leadership, elements that could over time strengthen local clinical capacity and reduce the need for foreign specialist teams who only occasionally operate in the country. Overall, the Italian intervention addresses one of the determinants of healthcare migration (the availability of diagnostic technologies and functioning operating rooms), but does not directly address other relevant determinants, such as the perception of clinical safety, trust in the local healthcare system, and communication with the population and social groups who choose to travel abroad for reasons not strictly related to technical availability.

D.9.2 Have spillover effects been recorded on structures that are not directly beneficiaries?

Testimonies gathered during interviews indicate that, to date, no significant spillover effects have occurred to healthcare facilities that are not directly benefiting: the intervention remains limited to the nine selected facilities, without a mechanism to extend its impact to the rest of the Congolese healthcare system. In fact, the decision to define such a concentration at the contractual level mirrors the agreements reached during the PSD and appears to be acceptable in terms of efficiency, as previously mentioned. On the other hand, some complementary initiatives could have led to more general positive impacts on the Congolese healthcare system. In particular, adequate dissemination of information on the new technologies made available by the project could ease the pressure on other facilities, directing patients to the rehabilitated facilities, which are better able to absorb the influx. Furthermore, regarding maintenance activities, the project's activities could be integrated with the Ministry of Health's training and maintenance system, which, as noted in the testimony of the Director of Equipment, is struggling with significant human and financial resource constraints. The Italian project operates exclusively within the single facility, albeit in collaboration with local technicians, but without any indication of interventions or exchanges of expertise with other hospitals in the Congolese healthcare network.

During the interview at Talangaï Hospital, when asked whether they were considering "continuing in this area or expanding support to other services that need it," the response was that they preferred to expand internally to other departments within the same hospital rather than to other external healthcare facilities. This confirms that even in the view of local providers, spillover, where

envisioned, involves internal expansion of services within their own hospital and not diffusion to other facilities.

A final finding gathered during the assessment mission concerns the presence of equipment purchased from other international donors, which often remains unused because it is not installed or maintained. This represents a further potential for spillover to other facilities, which remains untapped to date and could increase the effectiveness of the Italian intervention in terms of concrete impact on the system.

Q.10. To what extent has the program contributed to reducing disparities in access to health services, with attention to gender, minors, and populations in underserved areas?

- The geographic distribution of the nine facilities reflects the concentration of health resources in Congo's main urban centers, with only one opening to two additional departments (Niari and Cuvette). This does not address the regional imbalances highlighted in both the National Strategy Documents (PNDS) and the WHO Health District Revitalization Strategy. Field testimonies confirm that populations in peripheral areas and primary health centers remain effectively excluded from the direct benefits of the intervention.
- The program has seen specific improvements in the availability of relevant services and technologies for obstetrics, neonatology, and pediatrics, particularly in facilities where neonatology, intensive care, and maternal and child care departments have been established or expanded. However, the heterogeneity and incompleteness of statistical data, the very short observation period, and the persistence of clinical, training, and infrastructure deficiencies prevent the program from achieving a measurable reduction in maternal and neonatal mortality. Its contribution should therefore be interpreted, at this stage, as strengthening the technical and organizational preconditions necessary to achieve better maternal and child health outcomes in the medium term.

Q. 10.1 Did the geographical distribution of the 9 facilities ensure equitable access to the populations of the inland regions?

The project document noted that 62.7% of the country's health personnel are concentrated in Brazzaville and Pointe-Noire, and that 77.7% of doctors work in these two cities, compared to a national health personnel density well below the WHO standard of 4.4 per thousand inhabitants. Of the nine supported facilities, four are located in Brazzaville (Centre National de Transfusion Sanguine, Hôpital de Référence de Talangaï, Hôpital de Référence de Makélékélé, Hôpital Spécialisé Mère-Enfant Blanche Gomes), two in Pointe-Noire (Hôpital Général Adolphe Sicé, Hôpital Général de Loandjili), one in the Niari district (Hôpital Général de Dolisie) and two in the Cuvette department (Hôpital Général Edith Lucie Bongo Ondimba d'Oyo, Hôpital Général 31 Juillet d'Owando). The geographic distribution of the nine facilities supported by the Italian intervention does not guarantee equal access to the populations of the internal regions of Congo, as it reproduces and even reinforces the historical concentration of healthcare resources in the country's two main urban centers, leaving much of the national territory unserved.

The project document also referenced the WHO strategy linked to the 13th General Programme of Work, which focuses on the revitalization of health districts and the promotion of primary care. Since 2020, this initiative has improved access to quality care for approximately 700,000 people, equivalent to 13% of the general population, and limited to 12 of the country's 52 health districts. This data confirms that, even at the national strategy level, equitable health coverage remains a distant goal on a national scale. The Italian intervention, focusing on referral facilities located primarily in the two

largest urban centers and only two additional departments, does not significantly contribute to expanding this district base. It remains complementary to the mechanism for the revitalization of peripheral health districts promoted by the WHO and the PNDS 2023-2026 in its strategic axis no.

Interviews conducted in Pointe-Noire with departmental health officials provided direct evidence of this imbalance: the director of the Pointe-Noire health department, responsible for 36 primary health centers serving a catchment area of 1.5 million people, reported that he was not involved in selecting the equipment required by the Italian project, since "the Italian project works with general hospitals," while primary health centers, under his jurisdiction, were excluded from the intervention. The director himself emphasized that the lack of preventative maintenance and continuity of electricity and water supplies particularly severely affects peripheral primary health facilities, not covered by the project, and explicitly requested the Italian government to train preventative maintenance teams that extend to this level of care, highlighting a need that the current intervention design does not address.

It's true that the Italian intervention was conceived as a pilot project, so its overall impact was considered limited from the outset. However, the initiative's test value should have included a series of collateral actions, both informational and educational, capable of amplifying its reach. However, at this stage, no system has been activated to connect the populations of the more peripheral areas, including inland areas, to the relevant structures supported by the project.

Q.10.2 Have obstetrics, neonatology and paediatric services seen specific improvements?

The evaluation confirmed that the program has produced specific and visible improvements in maternal and child services where these departments were included among the intervention's priorities. These improvements primarily concern the availability and functionality of essential equipment, the restoration or redevelopment of some clinical units, and, in some cases, the strengthening of newborn care and obstetric emergency capacity. However, based on currently available data, it is not possible to conclude that the intervention has yet resulted in a measurable and attributable reduction in maternal and neonatal mortality.

The interventions directly affected several facilities with a significant focus on maternal, neonatal, and pediatric healthcare. At the Hôpital de Référence de Makélékélé, the neonatology unit, previously absent, is now operational; at the same time, the intensive care unit has been reequipped. According to observations gathered during the mission, these units were explicit priorities for the facility. However, a crucial critical issue remains: the oxygen supply to the unit depends on interventions under Congolese jurisdiction that had not yet been completed at the time of the visit.

At the Mère-Enfant Blanche Gomes Specialized Hospital, the intervention involved departments closely related to the maternal and child care pathway, including neonatology, pediatrics, emergency gynecology, as well as ophthalmology and stomatology. The interim audit report documented the delivery and installation of essential equipment for the facility's neonatology unit, including a pediatric phototherapy device, incubators, a transport incubator, multi-parameter monitors, a centralized monitoring system, a mobile ultrasound scanner, precision scales, intensive care or resuscitation beds, defibrillators, and surgical aspirators. This equipment represents a tangible improvement in the potential capacity to care for fragile, premature, or newborns with conditions requiring monitoring and stabilization.

Testimonies from Talangaï Hospital indicate that the rehabilitation and expansion of intensive care areas have created potentially significant conditions for managing obstetric and pediatric emergencies. Hospital staff reported that support for equipment repairs, including heating pads, had a positive impact on the care of newborns and, according to the staff, contributed to reducing neonatal mortality. This evidence represents an important qualitative signal, but cannot be

considered quantitative evidence of impact, as it is not accompanied by standardized data on cases treated, live births, clinical severity of cases, and deaths averted.

At the Hôpital Général de Loandjili, the intensive care unit, with four rooms and a treatment room, has also been renovated, and staff training activities have begun following the installation of the equipment. The facility expressed satisfaction with the functionality of the renovated services and noted an increase in attendance. However, stakeholders emphasized that initial training cannot replace ongoing training and that additional priorities include radiology and diagnostics, which can also be crucial in managing maternal and neonatal complications.

Table 7: Data on maternal and neonatal mortality, 2024-2026 (Q1)

	Neonatal Deaths			Maternal deaths		
Structures	**2024**	**2025**	**Q1 2026**	**2024**	**2025**	**Q1 2026**
CNTS (Transfusion Center)						
HSME B. Gomes	206	79		6	9	
HG A. Sicè	208	379		21	18	24
HG de Loandjili	55	29	12	2	3	0
HG Dolisie	116	113	10	15	8	0
HG EL Bongo	45	32		2	5	
HG 31 July	17	16	3	2	4	0
HB Talangaï	21‰	13‰	115	284‰	24	14
HB Makelékelé			0			0

Source: Direction de l'information sanitaire et de la recherche du Ministère de la Santé du Congo - DISER

The data made available by DISER from 2024 to the first quarter of 2026 show varying trends across facilities. Some hospitals saw reductions in neonatal deaths between 2024 and 2025. At the same time, Hôpital Général Adolphe Sicé recorded an increase in neonatal deaths, from 208 in 2024 to 379 in 2025. At Talangaï, however, the data are expressed as a percentage and do not allow for a reliable comparison with the absolute values of other facilities. Regarding maternal mortality, the available data also show uneven variations: decreases were observed between 2024 and 2025 at Adolphe Sicé and Dolisie, while increases were observed at other facilities, including Blanche Gomes, Edith Lucie Bongo, and 31 Juillet.

These data, however, do not allow for a causal relationship with the program. First, the 2026 data series includes only the first quarter and therefore cannot be compared with full years. Second, the information is not homogeneous: some values are reported in absolute numbers, others in percentages, without the availability of common denominators (number of live births, neonatal admissions, assisted deliveries, severity of complications, or incoming transfers) necessary to construct comparable rates. Finally, a change in the absolute number of deaths may also reflect an increase in the capacity to attract and treat more complex cases, and not necessarily a deterioration or improvement in the quality of care.

Interpretative caution is particularly necessary considering that the program's logical framework placed the reduction of maternal and infant/neonatal mortality at the level of a general objective, with a time horizon of 2030. The national reference target envisages a reduction from 436 maternal deaths per 100,000 live births in 2018 to 300 by 2030, and from 52 infant and neonatal deaths per 1,000 live births in 2018 to 20 by 2030. These are therefore systemic and long-term changes, influenced by multiple factors that go beyond the mere availability of biomedical equipment.

Regarding the specific training provided, the interviews also highlighted that the activities carried out at Blanche Gomes were limited to four- to five-day sessions and that ongoing training was not implemented. The training provided by the program focused primarily on the use and maintenance

of equipment, without a structured clinical refresher course on diagnosis, management of obstetric and neonatal complications, or pediatric care. This limitation is significant: improving maternal and neonatal outcomes requires that new technologies be accompanied by updated clinical skills, care protocols, effective triage, early diagnosis capabilities, and multidisciplinary work.

Furthermore, enabling factors remain that are not fully assured. Interviews at hospitals repeatedly mentioned power outages, difficulties accessing spare parts and consumables, and, in some facilities, incomplete oxygen connections. In the case of Makélékélé, the lack of oxygen limits the full use of the neonatology and intensive care units; at Adolphe Sicé, the connection between the intensive care unit and the surgical block remains problematic, as the two units are on different floors and are not connected by an elevator. While these elements are not strictly within the scope of the project at this stage, they are nonetheless particularly critical constraints for realizing benefits in the care of obstetric emergencies, newborns with respiratory distress, and children requiring intensive care or rapid transfers.

4.6. Sustainability

Q.11. Are the financial and institutional conditions in place to ensure the continuity of the program's benefits after the end of the Italian funding?

- The financial conditions for ensuring the continuity of benefits currently appear to be rather limited: in the 2026 Congolese budget, the national budget for equipment maintenance alone amounts to 50 million FCFA, approximately €76,000, an amount disproportionate to the management of over 5,000 biomedical devices. Sustainability is also affected by the general financing framework for hospitals: personnel expenses absorb between 51% and 84% of hospital budgets, significantly reducing the margins available for preventive maintenance, spare parts, and technology renewal.
- Institutionally, this phase of the program was financed entirely through the Italian loan and grant components, without dedicated and quantifiable national co-financing. This does not conflict with the PSD regulatory framework, but leaves the definition of post-project financial responsibilities open.

Q.11.1 Has the Congolese government allocated its own funds for equipment maintenance in the 2026-2027 budget?

According to the Congolese state budget for the 2026 financial year, which the evaluation team was able to review, the Congolese government has not allocated a specific budget line for the maintenance of the project's equipment; the only identifiable funds for equipment maintenance remain generic, marginal, and unrelated to the Italian project. Under the heading "Hospital Equipment," the 2026 budget includes a specific line titled "APPUI AU PROJET ALTHEA EMPRUNT AIEA" for 1,000,000,000 FCFA (approximately €1.5 million), but the funding source indicated is coded "3250 ITALIE," meaning these are Italian funds transferred to the state budget. Therefore, for 2026, there is no national funding commitment dedicated to the project as such. The only item entirely financed with own resources, attributable to the maintenance of biomedical equipment, is the line "ACQUISITION ET MAINTENANCE DES EQUIPEMENTS GOUVERNEMENT", which increases from 40,000,000 FCFA in 2025 to 50,000,000 FCFA in 2026 (approximately 76,000 euros), a marginal increase and an amount completely insufficient compared to the scope of the fleet of over 5,000 biomedical equipment managed by the project.

In July 2026, during the evaluation mission, an important mid-term review of the activities of Congolese hospitals was held in Brazzaville as part of the healthcare reform process, led by the

Ministry of Health and Population. The aforementioned report confirms a structural problem with maintenance financing: obsolescence and insufficient functionality of technological resources are highlighted as the system's main weaknesses, and the recommendations to the Ministry call for "ensuring the financing of the Central d'Acchat des Médicaments Essentiels" and "regularizing the disbursement of operating subsidies to hospitals," the low rate of which is "the primary criticality reported by operators." Personnel expenses, in fact, absorb between 51% and 84% of hospital budgets depending on the type of facility, leaving almost no margin for maintenance and technical investments. Chronic underfunding of maintenance is therefore one of the main structural weaknesses of the Congolese health system, apparently not mitigated by the resources made available by the Italian intervention, which have not generated significant additionality.

Sources interviewed at the Ministry of Health's Equipment Service confirmed that "the Ministry has a budget for equipment renewal that is severely insufficient compared to needs," with planned investments that "often fail to be implemented" due to "bureaucratic delays regarding the actual availability of funds." In the same interview, it was stated that the intervention funded by Italian cooperation targeted only a few central hospitals, "with extremely limited impact on the entire system." This statement explains why the project did not have any structural consequences for the sector's 2026 national budget: since it was limited to nine facilities and managed with a dedicated and separate funding line, it did not trigger either the need or the opportunity to revise the national health system's resource allocation policy for maintenance. The direct involvement of the technical structures responsible for equipment and maintenance in the healthcare sector should have been greater: in the absence of this, it is logical that the project did not lead to any revision of the Ministry's internal financial planning practices, remaining an initiative managed "from outside" the ordinary budget chain.

Q.11.2 Has the financing model envisaged by the PSD actually been activated?

The legislative text of the Decree establishing and regulating the PSD in the Republic of Congo does not require a direct financial contribution from the delegating authority in the execution of the projects; rather, it provides for elements of guarantee to be borne by the delegatee, such as bank guarantees or first-demand guarantees (Article 107) and reimbursement guarantees in the event of advance payments exceeding 5% of the contract amount (Article 108). The only reference to possible public funding concerns the case in which "the delegated client is a legal entity governed by private law," in which case the decree provides "the conditions under which the client will advance the necessary funds... or reimburse the expenses incurred."

Documentary evidence for the project indicates that the funds actually mobilized were entirely of Italian origin (credit + grant), with no financial counterpart from the Congolese government during the implementation period, either in terms of direct contributions or budget increases. The audit report precisely certifies the bank transactions related to the project: the private contractor initially received two tranches totalling €30 million, corresponding exactly to the two transfers received by the Congolese state from Italy (€20 million from Cassa Depositi e Prestiti on June 16, 2025, and €10 million from AICS on August 22, 2025). The funds were transferred to two dedicated accounts in the name of the Ministry of Finance and Budget at the Congolese Treasury, funded solely by the two components of the Italian financing, with no mention of any additional contribution from the Congolese side. The audit therefore certified the traceability of the Italian flow only, without the activation of a SBS mechanism with related fungibility and/or the presence of bilateral co-financing.

In this regard, the MCIPPPP's Public-Private Partnerships Manager confirmed that the national government's contribution should be considered ongoing, not tied to a specific project; that is, it is generic support for the health system and not dedicated and quantifiable co-financing for a single project. Overall, the testimonies of Congolese officials indicate that any state contribution remains undefined, not accounted for in the reference period, and in any case structurally constrained by the financial limits of the national health budget. In the absence of an explicit regulatory requirement to

allocate national funds associated with the BS instrument, the entire financial component observed in the project management was found to be of Italian origin. This does not constitute a violation of the 2009 legal framework, but rather an implementation choice that left the issue of post-project financial sustainability undefined.

Q.12. To what extent do the results of Phase I provide a reliable and scalable evidence base for funding and designing Phase II?

- Phase I provided solid evidence regarding the PSD model's ability to rapidly deliver supplies, installations, and maintenance services to a limited number of facilities, thanks to the presence of a single operator already established in the country. However, this evidence refers to nine central hospitals and to an early stage, so it does not automatically assume that the same performance levels can be reproduced on a larger scale.
- The scalability of the model is limited by factors that already emerged in Phase I: the lack of dedicated national co-financing, technical dependence on the private operator, limited initial involvement of the Ministry of Health, and persistent infrastructure issues, particularly related to energy, oxygen, and consumables. Furthermore, the existing global service contract is limited to the nine hospitals for five years and provides for the possibility of suspension in the event of funding shortages.
- Phase I also highlighted that some risks envisaged in the initial design (inadequate reception capacity of the facilities, financial sustainability, and infrastructural conditions complementary to the equipment) remain relevant to the continuation of the initiative, while the risks of political and social instability and interruption of supplies have not materialized significantly.

Q.12.1 Can the PSD model be replicated at a larger scale while maintaining the performance levels achieved in Phase I?

The evidence collected allows for a nuanced assessment of the evaluation question: Phase I recorded solid and well-documented technical performance, but several structural elements point to concrete risks for the replicability of the PSD model on a larger scale, in the absence of significant corrective measures. Positive results in implementing the activities were achieved within a limited number of nine facilities and through the use of a single, consolidated supplier, conditions that must be carefully assessed in the event of expansion. The original project document envisaged the possibility of "easily replicating" the model in other healthcare facilities "in light of this initial experience... following appropriate assessments and adjustments," thus explicitly making replicability conditional on corrections and verifications. The aforementioned interviews noted that, as long as the intervention "affects a few central hospitals, the impact on the entire system continues to be extremely limited," and that the ministerial budget for equipment renewal remains "clearly insufficient compared to needs" without effective additional resources, a situation that would worsen with an expansion of the scope.

On the other hand, the operator Althea EM already has a five-year global service contract limited to the current nine hospitals "based on a government decision," with no possibility of extension to other sites during the term of the agreement, and with the clause that the contract may be suspended in the event of a lack of funding. This means that scaling up to make the necessary changes would require a complete contractual renegotiation, not a simple extension of the existing model. Some interviewees proposed incremental expansion for the next phase rather than a radically larger scale, with a ratio of "70% continuation of the same services already provided and 30% opening to new services or new hospitals." Below is a chart showing the main critical factors regarding a larger-scale evolution of the project, based on the evaluation evidence.

Table 8: Critical factors for scaling up

Factor	Evidence	Implication for scaling-up
National co-financing	Not activated in Phase I, 100% Italian funds	An expansion would require additional resources that are difficult to come by
Transfer of skills	Local technicians on hand but employed by the private operator	Risk of reproducing operator dependency on a larger scale
Institutional coordination	Ministry of Health excluded from initial negotiations	Weak governance that would worsen with more structures involved
Basic infrastructure (energy, oxygen)	Critical issues still unresolved in several Phase I hospitals	Non-guaranteed preconditions for new sites

Source: Evaluation Team Processing

Q.12.2 Are there any systemic risks identified in the design of the first phase that could jeopardize the continuation of the initiative?

The original project document had identified in a structural way a series of contextual and programmatic risks; experience during the implementation phase shows that some of these risks, while foreseen, still warrant strengthening mitigation measures in preparation for a possible second phase. The Evaluation Form carefully classified four main risk factors:

- the contextual risk, linked to a possible worsening of the political and social situation, was assessed as low probability but potentially high impact, with a monitoring system entrusted to the Italian Embassy and the provision of force majeure clauses;
- the programmatic risk related to inadequate national financial resources for the management of integrated health services was classified as medium probability and high impact, with mitigation expected through the rationalization of national funds and foreign direct investments;
- the risk of disruption in the supply of hospital materials and machinery was considered low probability but high impact, to be managed through careful supplier selection during the procurement phase;
- Finally, the risk of inadequate reception capacity of the target health facilities was also classified as low probability, despite having been identified on the basis of a needs analysis conducted with the local counterpart.

Regarding the facilities' reception capacity, interviews conducted during the assessment mission showed that the technical involvement of departmental and hospital staff in the planning phase could be further strengthened to ensure that supplies are fully aligned with the specific conditions of each facility. This is an area where the project already has clearly identifiable room for improvement, which provides a starting point for future corrective measures.

In terms of financial resources and management sustainability, some infrastructure challenges remain, complementary to equipment investments, such as electricity distribution and the procurement of consumables. It should also be acknowledged that the implementing company has provided support that, in some cases, exceeded the contractual obligations required, a sign of positive operational commitment. The conditionality mechanism linked to the disbursement of SBS installments, currently focused on expenditure verification, should also evolve toward a more direct link to results, a natural progression for budget support programs that mature over time and which would further strengthen the robustness of the chosen mechanism.

The contextual risk relating to political and social stability, as well as that of supply disruption, did not appear to have manifested itself significantly, confirming the adequacy of the related probability assessments in the original plan.

The evidence collected offers constructive guidance for a potential Phase II design. It is possible to consolidate an integrated sustainability strategy for each of the three pillars of the intervention (supply, training, and maintenance), taking into account both infrastructure aspects, the availability of consumables, and ongoing training for local personnel. It appears necessary to balance investments in biomedical equipment with an overall system upgrade, also leveraging synergies with other local operators in the sector as a complementary lever for sustainability.

5. CONCLUSIONS, LESSONS LEARNED, AND RECOMMENDATIONS

5.1. Conclusions

Relevance

1. The intervention addressed the priority and structural needs of the Congolese hospital system, combining technological availability, maintenance, and training in a potentially more effective approach than simply providing equipment. However, the relevance of the general approach was diminished by the limited participation of hospital management and local technical units in defining specific priorities, resulting in mismatches between some supplies and actual conditions of use in the departments.
2. The decision to concentrate the intervention in nine hospitals allowed resources to be focused on referral facilities, but it favored the main urban centers and did not adequately integrate criteria of territorial equity, accessibility of peripheral populations, and maternal and child health. The contribution to the most disadvantaged should therefore be interpreted primarily as indirect and potential, rather than the result of a design explicitly focused on vulnerabilities.

Coherence

3. The project is consistent with the PNDS priorities regarding strengthening general hospitals, improving technological infrastructure, and developing biomedical maintenance. It also complements the WHO strategy for revitalizing health districts, but this complementarity has remained largely programmatic: no operational tools have been developed to connect primary care, district hospitals, and referral hospitals.
4. The use of the PSD has facilitated the mobilization of specialized technical and logistical capabilities, but its overlap with funding defined as Sector Budget Support has led to governance ambiguities. The concentration of decision-making within the Ministry of Cooperation, the unequal involvement of the Ministry of Health and the Ministry of Finance, as well as limited coordination with WHO, the World Bank, UNFPA, among others, and national technical directorates, have weakened the initiative's institutional coherence and reduced opportunities for synergy.

Effectiveness

5. The first phase achieved significant operational results: the planned equipment has been largely installed and inventoried, technical laboratories, call centers, and an equipment management system have been activated, while the beneficiary facilities now have improved potential for diagnostic, surgical, emergency, and, in some locations, maternal and child care services. However, the full translation of supplies into clinical services remains dependent on the completion of essential infrastructure elements, such as oxygen and other medical fluid networks, power continuity, air conditioning, radiation protection, and internal facility accessibility.

6. The on-the-job training model has initiated a transfer of skills in maintenance and technology use, but there is insufficient evidence to verify the achievement of the target for improving staff skills. The lack of baseline and post-training tests, the persistent reliance on technicians from the private operator, and the lack of a formalized training program for trainers indicate that local technical autonomy is still in its infancy and is not a consolidated result.

Efficiency

7. The implementation model allowed for very rapid supply and installation and the activation of a maintenance service with significant response capacity. The financial conditions associated with the disbursement of the tranches supported this acceleration, but they primarily oriented the system toward fund absorption and contractual compliance, without introducing equivalent incentives for clinical quality, effective use of equipment, capacity building, or system sustainability.

8. Financial management features positive elements of traceability and accounting separation between aid credit and grants; however, the flat-rate nature of the PSD does not allow for the precise attribution of resources to the individual components of supply, maintenance, and training. COPIL has played an active supervisory role, but the lack of a single framework of indicators, baselines, and binding follow-up mechanisms has limited the ability to use monitoring to promptly guide corrective actions.

Impact

9. The program has helped increase the potential capacity of beneficiary facilities to provide more advanced diagnostic, surgical, and emergency services. However, the time since the actual launch of activities is too short to attribute measurable effects to the project on maternal and neonatal mortality, a reduction in medical evacuations, or the use of treatment abroad; these outcomes also depend on factors external to the intervention, such as drug availability, clinical expertise, safety of care, referral networks, and public trust.

10. The initiative's impact so far remains concentrated within the nine beneficiary facilities. Structured mechanisms for dissemination to other hospitals, the network of peripheral services, or the national maintenance system have not yet emerged; the potential for broader impact will depend on the ability to integrate the model with the Ministry of Health, promote exchanges between facilities, and leverage equipment provided by other partners that has not yet been used or maintained.

Sustainability

11. The financial sustainability of the model appears fragile. National resources available for maintenance are very limited compared to the needs arising from the management of over 5,000 registered biomedical devices, and hospital budgets are largely absorbed by personnel costs. In the absence of a multi-year national co-financing program for preventive maintenance, spare parts, consumables, and technological renewal, the continuity of these results will remain dependent on continued external support.

12. Institutional sustainability will depend on transforming the current model, heavily reliant on private operators, into a capacity permanently assumed by hospitals and the Ministry of Health. This transition also requires the progressive transfer of skills, tools, access to the EASI system, data, procedures, and maintenance responsibilities, as well as the inclusion of local technicians in a national framework for ongoing training and management of the biomedical infrastructure.

5.2. Lessons learned

1. Integrated design and relevance

The project confirms the validity of a model that combines biomedical technologies, maintenance, and training, overcoming the limitations of initiatives focused solely on the supply of equipment. However, the actual effectiveness of these investments depends on the presence of infrastructural prerequisites that must be considered an integral part of the model and not factors external to its scope.

Concentrating resources on a limited number of objectives has enabled visible results and the management of a complex technological investment, but has shown limitations when not accompanied by a participatory needs analysis. Relevance therefore depends not only on consistency with national priorities, but also on the alignment of existing resources, capabilities, and local priorities, and on careful consideration of the inclusion of the most disadvantaged groups and areas.

2. Governance and coordination

Entrusting implementation to a specialized operator through the PSD has accelerated the timeline, making available technical, organizational, and logistical capabilities that public bodies would otherwise find difficult to mobilize in the short term. Experience shows, however, that the effectiveness of a private operator does not replace the need for technically informed public governance, capable of guiding priorities, monitoring execution, and gradually taking ownership of results.

The coexistence of Sectoral Budget Support and PSD highlights the need for full coherence between the financing method, contractual mechanisms, and supervisory arrangements. In the observed model, the SBS primarily regulated the financial aspect, while the PSD governed the actual implementation; the limited integration between the two approaches generated uncertainties regarding responsibilities, duration, indicators, and reporting.

3. Capacity and monitoring

The rapid delivery and launch of maintenance services is a significant achievement of the applied model, but it does not equate to the strengthening of local capabilities. Installation, inventory, and corrective maintenance can progress rapidly; however, the transfer of skills, appropriate use of technologies, preventative maintenance, and accountability by the facilities require more time and continuous support.

Monitoring focused on spending, contractual commitments, and installed equipment can promote rapid implementation, but it is insufficient to measure the quality and sustainability of results. Evidence shows that the lack of baselines and a single set of indicators has limited the ability to comparably assess the actual functionality of technologies, clinical use, staff learning, and progress toward broader health outcomes.

4. Sustainability and systemic impact

The systemic impact of an initiative requires specific conditions for the experience to be transferable and applicable beyond the contractual scope. The functional connection between the various components of the healthcare system must be addressed during the project design phase, to generate structured mechanisms for dissemination to other hospitals, local services, or the national equipment management system.

Institutional sustainability depends on the gradual transition from an externally managed service to a stable public capacity. Experience shows that laboratories, digital platforms, specialized technicians, and supply chains can ensure an effective response in the short term, but their long-

term sustainability requires that skills, access, data, procedures, and responsibilities be effectively incorporated into hospital facilities and the technical departments of the Ministry of Health.

5.3. Recommendations

1. Formalize the scope and logic of Phase II

Phase I was implemented through documents that indicated durations, outcomes, indicators, and operating methods that were not fully aligned. The overlap between the Sectoral Budget Support and PSD mechanisms also created uncertainty regarding responsibilities, the role of public stakeholders, and the initiative's actual timeframe.

Before launching Phase II, the parties should adopt a single programming document, approved by COPIL and binding on all stakeholders, which will ensure consistency in the implementation methods (SBS, PSD). The document should clearly define: the duration of Phase II; the structures and departments involved; expected results; activities and budgets for each component; responsibilities of the Congolese government, the private operator, and the Italian party; monitoring mechanisms; reporting obligations; and conditions for moving to the next phase.

2. Establish effective technical-institutional governance

In Phase I, information remained primarily concentrated within the MCIPPPP and the operator, while the involvement of the Ministry of Health, the Ministry of Finance, the technical directorates, and hospital facilities was inconsistent. COPIL made pertinent observations, but lacked a continuous technical structure capable of verifying their implementation.

Phase II should include two distinct and complementary levels of governance:

- a Steering Committee (COPIL) with strategic and decision-making functions, responsible for approving annual plans, progress reports, any significant changes and financing tranches;
- A Technical Monitoring Committee, coordinated by the Ministry of Health and composed of the Planning, Hospitals, and Equipment Directorates, the MCIPPPP, the Ministry of Finance, the relevant hospital directors, and the Italian National Association of Hospitals (AICS). The Technical Committee should meet at least quarterly, maintain minutes and action plans with responsibilities and deadlines, validate the technical conditions for supplies, and formally report to COPIL.

3. Ensure integration with policies and partners

The intervention was generally consistent with the PNDS, but operational coordination with WHO, the World Bank, UNFPA, UNESCO, and other stakeholders was sporadic. The lack of systematic exchange limited potential synergies, including the recovery of equipment funded by other donors but not yet used.

By the operational launch of Phase II, the Ministry of Health should convene a technical coordination committee with key sector partners, with the mandate to: map existing equipment and investments; identify duplications and gaps; agree on the distribution of intervention areas; and define potential complementarities in training, maintenance, maternal and child health, and referral systems. The committee should update the mapping at least annually and submit its findings to COPIL.

4. Building a framework of results, indicators and conditionalities

The Phase I design was characterized by inconsistent outcome indicators and unavailable baselines; the conditionalities for resource disbursement favored spending thresholds and contractual

commitments, without prescribing measurements of the full functionality of services, capacity transfer, and the level of public ownership of the model.

Conditionalities for the first financial disbursement of Phase II should include the presence of a common monitoring framework, comprising: baselines for each facility and department; annual targets; verification sources; collection frequency; validation responsibilities; and corrective action thresholds. Conditionalities for subsequent financing tranches should combine financial criteria with performance milestones, including at a minimum: equipment commissioning; completion of enabling infrastructure; availability of spare parts and consumables; preventive maintenance performed; EASI functionality; trained and evaluated personnel; and effective use of technologies in the targeted services.

5. Integrate clinical priorities, infrastructure capabilities, and technology supplies

In Phase I, the selection of equipment and recipient departments was not always accompanied by a prior and shared analysis of the facilities' priorities and capacity to fully utilize them. Specifically, the availability of biomedical technologies did not always coincide with the completion of infrastructure and services essential to their operation, such as oxygen and medical fluid networks, power supply and UPS protection, water, air conditioning, radiation protection, department accessibility, technical spaces, consumables, and spare parts. The distinction between supplies and rehabilitation works, although clearly defined in the assignments of responsibilities, therefore limited the actual commissioning of investments in some cases.

Phase II should be conceived and planned as a fully integrated intervention, in which biomedical supplies, infrastructure rehabilitation, maintenance, availability of consumables, and staff training are inseparable components of a single plan for each facility and department. Before each investment is approved, a Hospital Development Plan should be developed and validated, prepared in collaboration with the hospital management, the relevant departments of the Ministry of Health, and the Technical Monitoring Committee. The Plan should indicate, for each department: clinical priorities; planned equipment; rehabilitation works and necessary technical requirements; costs and responsibilities for implementation; available staff and training needs; spare parts and consumables requirements; completion schedule; and criteria for testing and full commissioning. Approval of supplies should be subject to documented verification of the feasibility of the infrastructure works and the definition of binding commitments, with clear deadlines and responsibilities.

6. Differentiate the supply, maintenance and training components in the operational and financial plans

Phase I treated the program's three pillars as integrated components, but the PSD's flat-rate remuneration model and the compressed execution timelines made it difficult to identify specific resources, deliverables, and responsibilities for each component. Maintenance and training, which require longer timescales, therefore risk being under-resourced compared to the completion of supplies.

The Phase II operational plan and budget should clearly distinguish the three lines of operations (supplies, maintenance, and capacity building) with their own objectives, activities, resources, timelines, and indicators. The maintenance component should include preventive plans for the facility, minimum levels of spare parts availability, response times, and intervention records; the training component should be multi-year and not limited to the installation phase.

7. Strengthen the transfer of skills and ownership of maintenance systems

In Phase I, on-the-job training was not accompanied by systematic assessments of learning or training mechanisms for trainers. Similarly, the administration and use of the EASI system for

equipment inventory and maintenance tracking remains heavily concentrated within the operator, with access and management capabilities not yet consolidated within hospital facilities and the technical departments of the Ministry of Health.

Phase II should include an autonomous component for the transfer of skills and public ownership of the maintenance system, with dedicated resources, a timeline, indicators, and verifiable responsibilities. Hospital technicians and ministerial focal points should be appointed for each beneficiary facility, integrated into a progressive program that combines theoretical training, practical support, exercises, and biannual assessments, and certification of acquired skills. Phase II should define a verifiable assignment of access, roles, and responsibilities for the EASI system to hospitals and technical departments, ensuring institutional ownership of the data and the operational continuity of the platform after the private operator's support ends.

8. Connecting strengthened services to the territorial network

The project improved the potential capacity of the participating hospitals, but did not develop sufficient tools to enable peripheral populations, primary care facilities, and district hospitals to identify and utilize the enhanced services. This limitation is particularly relevant for maternal, neonatal, and emergency cases that require timely intervention.

For each Phase II hospital, hospital and departmental management should develop a referral plan that identifies: available services; clinical referral criteria; referral and counter-referral facilities and contacts; transportation options for urgent cases; and information tools for community workers and the general public (in collaboration with NGOs already active in the area). Data on the number, origin, and outcomes of referred patients should be included in program monitoring. A community communication and information plan should be developed to publicize the improved healthcare availability. Visibility of the intervention overall should be strengthened.

9. Defining a path to financial sustainability

The project's sustainability at this stage still depends largely on Italian support and the private sector's efforts. Available national resources are limited compared to the management needs of an expanded biomedical park, and there is no clear plan for the public system to gradually assume these costs.

As part of the development of the SBS agreements, the Congolese side should approve a multi-year financial sustainability plan, certifying the availability of additional resources for: preventive and corrective maintenance, spare parts, consumption, IT platform connectivity and operation, technical staff, and equipment renewal. The plan should identify funding sources, budget items, co-financing quotas per facility, and annual commitments from the Ministry of Health and other relevant institutions.

10. Valorising Phase II as a system intervention

The results of Phase I have remained largely confined to the nine beneficiary facilities. The initiative has not yet generated organized mechanisms to transfer expertise, deploy the maintenance model on a larger scale, or contribute to the deployment of technologies already present in other facilities and/or funded by other partners.

Phase II should include a systemic expansion component, defined based on the national mapping of equipment and skills: support for the reactivation of unused technologies; connection of technical laboratories to a reference network; mentoring between hospitals; national mapping of biomedical technicians; and definition of common standards for inventorying, maintenance, and equipment management. This component should be progressive and contingent on the stabilization of capacity in Phase I facilities.

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ANNEX I – Terms of Reference

Ministero degli Affari Esteri
e della Cooperazione Internazionale

· **MINISTRY OF FOREIGN AFFAIRS AND INTERNATIONAL COOPERATION**

DIRECTORATE GENERAL FOR DEVELOPMENT COOPERATION

Office VII

TERMS OF REFERENCE FOR THE

INDEPENDENT EVALUATION OF THE INITIATIVE

"Support program for the Republic of Congo for the development of integrated health services"

AID 13158

Impact evaluation

1. Object of the evaluation

· 1.a. Context

The Republic of the Congo (Congo-Brazzaville), located in Central Africa, covers an area of approximately 342,000 km² and has an estimated population of over 6 million in 2023. It is one of the continent's least densely populated countries, with an average of 15.5 inhabitants per square kilometer. However, the population distribution is highly uneven: more than half of the population is concentrated in the departments of Brazzaville and Pointe-Noire, which alone account for 58.2% of the total population.

The Congolese healthcare system is organized into three levels: a central level, comprising the Ministry of Health and its general directorates; an intermediate level, consisting of 12 departmental directorates; and a peripheral or operational level, divided into 52 health districts divided into health zones. The national healthcare policy is based on an ambitious vision: to build an efficient and resilient healthcare system capable of ensuring universal access to quality healthcare and good health for the entire population. This objective is part of a broader vision of the country's sustainable development and involves eliminating all forms of exclusion or discrimination, while promoting the active participation of the population.

In line with Sustainable Development Goal (SDG) 3, dedicated to health and well-being, Congo joined the World Health Organization's 13th General Programme of Work, launched in 2019. The Ministry of Health, in collaboration with the WHO, has therefore implemented an operational strategy focused on revitalizing health districts and strengthening primary health care. Since 2020, this strategy has been integrated into the National Health Development Plans, with the aim of improving access to care in 12 health districts, reaching approximately 700,000 people.

The 2023-2026 National Health Development Plan fits into this context. It aims to strengthen the health system and governance through high-impact interventions designed to significantly reduce mortality and morbidity, especially among the most vulnerable segments of the population, such as women and children. The plan is structured around four main strategic axes/programs:

- strengthening health sector governance and financing;
- promotion of the health and well-being of the population;
- improving equitable access to essential, quality health services;
- strengthening health security and emergency management.

As planned, the program being evaluated involves several general referral hospitals, including Blanche Gomes, 31 July General Hospital, Loandjili, Adolfo Sicé, Dolisie, and Oyo. It also includes the National Blood Transfusion Center and several district hospitals, such as Makélékélé and Talangai, which are part of a pilot project for the development of secondary care facilities.

From an operational standpoint, the Program's strategic approach was based on three fundamental pillars: the first concerns the training of medical and technical personnel, who were trained in the use and maintenance of electromedical equipment, with the aim of transferring skills to local personnel; the second pillar is technological innovation, through the replacement of obsolete equipment and the provision of new technologies compliant with European standards; and finally, the third pillar concerns the independence of the healthcare system, which in the medium to long term must become self-sufficient in the management and maintenance of biomedical technologies.

The Project's main objectives are to improve hospitals' capacity to provide advanced care, accurate diagnoses, and effective therapies, and to create a more integrated healthcare system where patients can access facilities suited to their needs.

The revitalization of health districts is currently a major challenge for the Congolese government and all technical and financial partners in the health sector, including the European Union and the World Bank (WB), which have provided grant funding and soft loans over time.

The initiative was requested by the Government of the Republic of Congo with a note from the Ministry of International Cooperation and the Promotion of Public-Private Partnerships dated September 26, 2024, and was approved by the Joint Committee for Development Cooperation with resolutions no. 109 and no. 110 of September 30, 2024. The Agreement between the Government of the Italian Republic and the Government of the Republic of Congo was signed in Rome on November 24, 2024. The Program provides a total allocation of €45 million, of which €35 million in the form of a concessional loan and €10 million in grants, intended to strengthen the Congolese healthcare system through the sector budget support instrument.

The attached descriptive sheet contains information related to the forecast document. During the Desk Analysis phase described in the management instructions and work plan, further documentation will be provided after the official start of work has been announced.

· 1.b. Usefulness of the evaluation

The evaluation aims to provide an independent and systematic analysis of the initiative according to OECD-DAC criteria in order to assess the results, effects, and sustainability of the interventions, and to generate strategic learning to support future programming decisions and the formulation of new initiatives.

The initiative's impact assessment will also focus on the declared development objectives, considering direct, indirect, expected, and unexpected effects.

Given the recent conclusion of the initiative, this evaluation takes on a particularly strategic role in understanding not only the initial observable effects, but above all the potential future impact of the intervention on the Republic of the Congo's healthcare system. From this perspective, the analysis will focus on the robustness of the changes initiated and their ability to generate lasting benefits in the medium to long term, consistent with national priorities and the Sustainable Development Goals, particularly Goal 3 on health and well-being.

The Evaluation Team will:

- Analyze whether the conditions exist to foster the sustainability and scalability of the results achieved, examining the extent to which the three pillars of the intervention—staff training, technological innovation, and strengthening management autonomy—can continue to produce lasting effects. This includes, for example, the ability of trained staff to transfer skills, the maintenance and effective use of the equipment provided, as well as the effective autonomy of healthcare facilities in managing biomedical technologies.
- Analyze the extent to which the intervention has contributed to improving the population's access to quality healthcare services, considering aspects such as the availability and continuity of diagnostic and therapeutic services, reduction of waiting times or referrals to other facilities, as well as the ability of healthcare facilities to respond promptly and effectively to the population's health needs. Particular attention will be paid to equity in access, verifying whether the

intervention's benefits have also reached vulnerable groups or more disadvantaged areas, thus helping to reduce territorial and socioeconomic disparities in healthcare provision.
- Explore plausible trajectories of change, identifying enabling factors and risks that could influence the achievement of the expected impact, such as the level of integration into the national health system, the availability of financial resources, and the continuity of institutional support. In this sense, it will provide useful information to guide possible corrective actions or complementary interventions, in order to maximize the initiative's benefits over time.
- Contribute to generating forward-looking evidence to support public decision-makers and technical and financial partners, fostering strategic learning and informing the design of future initiatives, with a view to progressively strengthening a more resilient, equitable, and self-sufficient healthcare system. In this sense, it will represent a fundamental tool for guiding future decisions and defining more targeted intervention priorities.

· 1.c. General objectives of the evaluation

The evaluation aims to provide an independent, rigorous, and learning-oriented analysis of the recently concluded initiative, systematically examining its results, initial observable effects, and potential medium- to long-term impact on the Republic of the Congo's health system.

This evaluation is configured as a Programme evaluation conducted in accordance with the OECD-DAC criteria (2019), with particular emphasis on the impact criterion.

The evaluation must express a general, adequately reasoned opinion on the relevance of the initiative's objectives to the needs and priorities of the intervention contexts, as well as on their internal and external coherence, both with other Italian Cooperation initiatives and with those promoted by other donors.

Particular attention should be paid to the qualitative impact of the initiative being evaluated as a whole, and therefore describe the changes it has contributed to, or is expected to contribute to, directly or indirectly, with particular attention to the prospects for consolidating the changes initiated within the social, economic, and environmental context. The analysis should correlate these effects with the level of achievement of the objectives indicated in the attached descriptive sheets and with other relevant development indicators, prioritizing a reasoned and qualitative assessment of the overall impact.

Based on the results achieved and in line with the OECD-DAC criteria, also taking into account the indicators listed in the logical framework, the effectiveness of the interventions, the efficiency in the use of available resources and the sustainability of the benefits achieved will be evaluated. The project will also assess the relevance of the intervention to the needs of the national context and the priorities of the healthcare sector, including from an institutional, economic, social, and environmental perspective, the initiative's internal and external coherence with national policies and international partners' interventions, and its effectiveness in achieving the intended objectives. The project will also examine the efficiency of the use of available resources, the quality of implementation mechanisms, and the sustainability of results, analyzing the institutional, technical, and economic conditions necessary for the intervention's benefits to be sustained over time, especially in light of the project's recent conclusion.

From this perspective, the evaluation aims not only to account for the results achieved, but also to identify enabling factors, critical issues, and plausible evolutionary trajectories, helping to guide future strategic decisions, improve policies, and define new initiatives in the healthcare sector.

Specifically, the evaluation will focus on the initiative's ability to contribute to the structural strengthening of the healthcare system, analyzing improved access to quality services, enhanced diagnostic and therapeutic capabilities, and its impact on the quality of care provided, especially for the most vulnerable groups. The contribution of the intervention's three pillars—staff training, technological innovation, and strengthening managerial autonomy—to generating systemic change will also be examined, assessing their transformative and replicable potential. The evaluation will also explore the enabling factors and risks that may influence the achievement of the expected impact, such as the degree of integration into the national healthcare system, the availability of resources for technology maintenance, and the continuity of institutional support. In this way, it will provide useful evidence to understand not only whether and to what extent the initiative is producing an impact, but also how and under what conditions these impacts can consolidate and expand over time, guiding future strategic and planning decisions.

The evaluation's conclusions will be based on objective, credible, reliable, and adequately triangulated evidence, enabling the DGCS to develop an appropriate evaluation management response. This will ensure that the lessons learned, best practices identified, and recommendations developed can translate into concrete changes in both strategic choices and operational methods, improving the quality, programming, formulation, and management of development cooperation interventions.
Any follow-up actions to the recommendations will be developed by AICS and the stakeholders to whom the recommendations are addressed.

Dissemination of the evaluation results will contribute to strengthening institutional accountability to Parliament regarding the use of funds allocated for Official Development Assistance (ODA) and to the Italian public regarding the effectiveness of the allocation of available government resources to cooperation activities. The evaluation results and lessons learned will be shared with the main cooperation agencies and local partners. The evaluation will also foster mutual accountability among partners regarding their mutual commitments.

Finally, by involving the partner country at every stage of its implementation, the evaluation will contribute to strengthening their evaluation capacity, encouraging ownership of the results and promoting an evaluation culture oriented towards learning and continuous improvement of development policies and interventions.
The evaluation team may suggest and include other aspects that are consistent with the purpose of the evaluation.

2. Evaluation Methodology

2.a.General principles and approach

a) The evaluation must be in line with the highest international reference standards, particularly in terms of integrity, respect for civil norms, local customs and traditions, human rights, gender equality and the principle of “do no harm”.

The evaluations conducted by the DGCS are based on the following principles: usefulness, credibility, independence, impartiality, transparency, ethics, professionalism, respect for human rights, gender equality, and the "leave no one behind" principle.

Cross-cutting issues (including human rights, gender, and the environment) should be adequately integrated and systematically analyzed, ensuring that their findings emerge clearly and across the entire evaluation process.

To assess the extent to which the intervention has contributed, on the one hand, to the promotion of human rights and, on the other, to the ability of rights holders to claim their effective enjoyment, the Human Rights Based Approach will be adopted.

The evaluation must be in line with the highest international reference standards and take into account the relevant Italian cooperation guidelines.

Cross-cutting issues (including human rights, gender, environment) should be given due consideration and evaluation results in these areas should be adequately highlighted in a cross-cutting manner.

b) More generally, the evaluation team will adopt an integrated approach that combines the Results-Based Approach (RBA) with a theory-based approach. The former will form the basis for a systematic analysis of evidence from various information sources (project documentation, logical framework, monitoring reports, interviews with institutional stakeholders, project staff, and beneficiaries, both individually and in focus groups). The latter will allow for a critical examination of the causal hypotheses underlying the intervention design, verifying ex post the validity of the theory of change and analyzing the mechanisms through which the results were (or were not) achieved.

Adopting a theory-of-change approach will also highlight some structural criticalities typical of development interventions. Specifically, the evaluation will analyze the clarity and robustness of the original theory of change, considering that many public policies are sometimes launched under conditions of uncertainty and without an explicit theoretical framework that coherently links activities and expected outcomes. The pluralism of the implementation framework will also be examined, verifying the extent to which implementation methods have been effectively adapted to the specificities of the local context or, conversely, have been influenced by standardized approaches.

From this perspective, the evaluation will not only measure the degree of achievement of the expected outputs and outcomes, but will also analyze the processes through which these results were generated, including the identification of unexpected effects, whether positive or negative, and the assessment of the attribution of observed or expected changes.

Specific attention will therefore be devoted to analyzing the implementation phase, with the aim of verifying the consistency between the project design and its actual implementation, as well as understanding the role and influence of the stakeholders involved on the results achieved.

If the interventions have not been structured according to a full Results-Based Management (RBM) logic or present gaps in terms of theory of change, indicators or baseline data, the team will proceed to adapt and integrate the methodological approach.

To this end, the evaluation team will undertake a mission to Congo.

The evaluation process should be utilization-focused, placing particular emphasis on the concrete use of the results and the resulting recommendations.

c) The evaluation team may adopt both qualitative and quantitative methodologies to triangulate the results obtained using each. When choosing the methodologies to use, the evaluation team must consider the objectives of the evaluation as well as the scope and characteristics of the intervention. The methods used for both the evaluation and for data collection and analysis must be clearly stated, justifying the choice and clarifying the methods used.

In any case, the methodologies used must be consistent with all the principles set forth above in points a and b. In particular, the gender perspective must always be integrated (in light of the type of intervention being evaluated) and must be specified in the technical proposal (for example, the presence of female or gender-specific personnel on the team, data collection and analysis disaggregated by gender, etc.).

In the initial evaluation phase, evaluators will have to:

- propose the main evaluation questions and additional questions, in a timely manner and taking into account the specific characteristics of the intervention;
- develop the evaluation matrix, which, for each of the evaluation questions and supplementary questions that have been decided to be considered, indicates the techniques that will be used for data collection and provides other information such as measurement methods, any indicators, the presence or absence of baselines and any other information appropriate based on the needs of the evaluation;
- establish the modalities for stakeholder participation in the evaluation, with particular attention to beneficiaries and the most vulnerable groups.
- reconstruct the theory of change, compatible with the methods of designing the interventions.

· 2.b. Quality of the evaluation:

The evaluation team will use several methods (including triangulation) to ensure that the collected data is valid.
The evaluation must comply with the OECD/DAC Quality Standards for Development Evaluation.[1]

· 2.c. Evaluation Criteria

The evaluation criteria to be adopted, recently redefined by the OECD-DAC, along with the reference principles for their use, form the basis for the overall analysis of the intervention. While referring to the OECD-DAC sources,[2]For a detailed analysis, evaluators are invited to pay particular attention to the following criteria:

- **Impact**: The significant impacts of interventions—positive or negative, expected or unexpected—will be analyzed beyond immediate results. The analysis will include social, economic, and environmental impacts, as well as impacts on key issues such as community well-being, human rights, and gender equality.
- **Relevance:** The evaluation team will assess how well the initiative's objectives and design meet the needs, policies, and priorities of the beneficiaries, the country, and partner institutions, even in changing contexts.
- **Sustainability**: the possibility of sustaining the benefits of the initiative in the medium and long term will be assessed, both with regards to those already achieved and potentially future ones.

[1] https://www.oecd.org/en/publications/dac-quality-standards-for-development-evaluation_9789264083905-en.html
[2]For the definitions of the OECD Criteria, please refer to the following link:https://www.oecd.org/en/topics/sub-issues/development-co-operation-evaluation-and-effectiveness/evaluation-criteria.html

- **Effectiveness**: the evaluation will measure the degree and extent to which the objectives of the initiative, understood in terms of direct and immediate results, have been achieved or are expected to be achieved, paying attention to the different results obtained in the various beneficiary groups.
- **Efficiency**: it will be analyzed whether the use of resources has been, or is expected to be, optimal for achieving the results, in economic, temporal and managerial terms.
- **Coherence:** The compatibility of the intervention with other initiatives in the same sector will be examined, both within the scope of Italian cooperation and with respect to the actions of other countries or actors involved.

· 2.d. Evaluation questions

Evaluation questions should be formulated primarily based on the evaluation's utility and objectives. The specific interpretation of the OECD-DAC criteria, as well as any additional criteria, will also depend on the evaluation's intended purpose and its intended use.
Questions about effectiveness and impact should be based on the level of specific outcomes and impacts generated, rather than specific outputs and overall, difficult-to-quantify impact.
To better evaluate the impact, some of the questions will have to be of the cause-effect type.
Some questions should address cross-cutting issues (poverty, human rights, gender or environmental issues, etc.).
The impact assessment must answer, by way of example and not exhaustively, the following evaluation questions:

- To what extent did the project improve the capacity of target hospitals to provide advanced care, diagnostic services, and effective therapies?
- To what extent is the biomedical equipment supplied operational, accessible, and adequately maintained over time?
- Did the project help reduce equipment downtime and improve continuity of healthcare services?
- To what extent have trained healthcare and technical personnel acquired adequate skills in the use, management, and maintenance of biomedical technologies?
- Did the training activities support sustainable skills transfer and the ability to train additional staff locally?
- To what extent have healthcare facilities and the Ministry of Health strengthened their autonomy in managing biomedical technologies and maintenance systems?
- What changes has the project brought about in the population's access to quality health services, particularly for the most vulnerable groups and in underserved areas?
- To what extent did the project contribute to improving the organizational and management efficiency of the healthcare facilities involved?
- What institutional, financial, organizational, or contextual factors facilitated or hindered the achievement of the intended results?
- Which elements of the intervention model offer the greatest potential for sustainability, replicability, and scalability in the medium to long term?

In any case, the questions (both main and supplementary) must be formulated independently by the Evaluation Team, taking into account the specific characteristics of the intervention, and elaborated in a clear and detailed manner, with an operational approach that also takes into account the concrete possibility of providing an answer.

· 2.e. Involvement of local stakeholders

The methods used must be as participatory as possible, involving the institutional recipients of the evaluation, the partner country, the beneficiaries of the intervention, and all the main stakeholders in general at all stages.
The evaluation team will involve local stakeholders in the evaluation process, planning, where possible and in coordination with the DGCS, AICS, and local counterparts, opportunities for discussion and sharing aimed at promoting an evaluation culture geared toward learning and the continuous improvement of development policies and interventions.

The local stakeholders are:

- Ministry of International Cooperation and Promotion of Public-Private Partnership (MCIPPP);
- Ministry of Economy and Finance of the Republic of Congo (MEF);
- *Banque des Etats de l'Afrique Centrale*;
- Ministry of Health and Population (MPS).

· 2.f. Evaluation team profile

The evaluation service must be carried out by an evaluation team composed of at least three members, including the team leader, who will be the DGCS contact for the entire procedure and will participate in the meetings and workshops envisaged in the work plan.

Team members must meet the following requirements:

FIGURE	MINIMUM REQUIREMENTS	PREFERENTIAL REQUIREMENTS
EXPERT (Team Leader)	• Bachelor's degree; • Proficiency in Italian, English and French, spoken and written; • Experience in evaluating development cooperation initiatives (at least 5 years); • Experience in coordinating multidisciplinary teams (at least 3 years); • In-depth knowledge of the RBM methodology and the tools and intervention methods of Italian Cooperation.	• Experience in evaluating development cooperation initiatives in the health sector. • Knowledge of the countries and the institutional context.
MID LEVEL / JUNIOR LEVEL	• Bachelor's degree; • Proficiency in Italian, English and French, spoken and written; • Experience in evaluating development cooperation initiatives	• Knowledge of the vehicular languages of the countries of intervention); • Experience in evaluating development cooperation initiatives in the health sector.

	(at least 1 year JL; at least 3 years ML).	• Knowledge of the countries and the institutional context.
LOCAL (optional, but recommended)	• Mastery of the vehicular languages of the countries of intervention (Lingala, Kituba); • Knowledge of the countries and the institutional context. • Knowledge of project cycle management and development cooperation projects.	• Experience in evaluating development cooperation initiatives in the health sector.

The evaluation team must also have the following skills, which may be possessed by one or more mandatory or additional members:

- Specific skills in the healthcare sector;
- Skills in interviews, documented research, data collection and analysis;
- Adequate expertise in cross-cutting and gender issues;
- Excellent analytical, editorial, and data presentation skills.

If any candidate does not possess knowledge of the target language, the evaluators are required to arrange for adequate interpretation services, ensuring full mutual understanding during all phases of the evaluation activities.

3. Products of the evaluation exercise

The outputs of the exercise will be:

- An Inception Report in Italian (approximately 20 pages), to be submitted to this office by the deadline agreed upon during the evaluation kick-off meeting at the DGCS (generally 20 days). The document must include a description of the evaluation scope, the main and supplementary evaluation questions, the criteria and indicators that will be used to answer the questions, the methodologies intended for data collection and analysis and for the overall evaluation, a definition of the roles and responsibilities of each evaluation team member, the work plan including the activity schedule, and the procedures for conducting field visits.

- A Final Report (approximately 50 pages, excluding attachments) in Italian and translated into French and English. The digital reports in all three languages must be submitted in Word and PDF format (max 3 MB) to Office VII – Evaluation Section. The contracting authority is also required to submit the report in Italian and English in paper format, bound in paperback, in three copies for each language (for a total of nine copies). The drafting and translation must be of a professional standard. The Report must also include infographic elements that facilitate reading and provide immediate clarity of the evaluation findings. Further information regarding the format and structure of the report is provided in the relevant factsheet.

- A Final Report Summary (maximum 15 pages), in Italian and translated into French and English. The report summaries in digital format in all three languages must be submitted to the contracting authority in Word and PDF formats (maximum 3 MB). The contracting authority is also required to provide the report summaries in Italian and French in paperback, bound in three copies for each language (for a total of nine copies). The paper copies must be laminated. The drafting and

translation must be of a professional standard. The summary report must include the scope and objectives of the evaluation, the methodological approach, the main conclusions, and the recommendations.

- **Photographic documentation** (in high definition) on the evaluated initiative and its context, supporting the evaluation conclusions, to be transmitted in digital format. The documentation must be acquired in compliance with applicable legislation on confidentiality and personal data protection.

- **Three PowerPoint presentations**, respectively in Italian, English and French, to illustrate the main findings of the evaluation (to also be used to support the scheduled workshops).
- Workshop to present the draft final report at the Ministry of Foreign Affairs and International Cooperation (MAECI-DGCS).
- On-site workshop for the presentation of the final report.

The following are:

- **Program description sheet;**
- **Management provisions and work plan;**
- **Suggested format of the Evaluation Report.**

· PROJECT DESCRIPTION SHEET

PROGRAM TITLE	"Support program for the Republic of Congo for the development of integrated health services" AID 13158
PROGRAM LOCATION	Republic of the Congo
PROGRAM LANGUAGE	French
EXPECTED DURATION	36 months
FUNDING CHANNEL	Bilateral
TYPE	Help Credit/Gift
TOTAL BUDGET	**EURO 45,000,000.00** *(forty-five million)* ***Of which 35,000,000.00 on credit*** ***10,000,000.00 as a gift***
IMPLEMENTING ENTITY	**Ministry of Health and Population (pursuant to art. 7 of law 125/2014)**
MILLENNIUM GOALS	SDG 3 T 3.1; T 3.2; T 3c

Context of the initiative

The Congolese Government aims to improve the health of its citizens by promoting the well-being of the population at all age groups through improved access to integrated, continuous, and person-centered healthcare. This Support Program aims to contribute to the Republic of the Congo's national budget in the health sector, promoting access to and expanding coverage of quality healthcare services in public hospitals and thus contributing to improving the population's health. This support is intended to promote the effectiveness and efficiency of the Congolese healthcare sector, specifically by strengthening the technical platform of the country's leading healthcare facilities through the supply of diagnostic equipment and quality surgical instruments, and by establishing a management mechanism for these facilities capable of ensuring their proper use and maintenance, supported by competent, trained, and specialized personnel, in line with the country's sectoral policies and strategic plans. This will enable the competent authorities to establish an autonomous, efficient, and standardized national healthcare technical platform management system, supported by the presence of local professionals with the necessary technical expertise to ensure its availability and effectiveness.

General and specific objectives

The overall objective is to contribute to improving access and expanding the coverage of health services for the population of the Republic of the Congo. The specific objective is to ensure the adaptation of the country's health facilities through the achieving a service performance standard.

Description of intervention strategy

The intervention strategy chosen to achieve the project objectives included the implementation of a set of activities aimed at strengthening the system. The project aims to improve service delivery through the revitalization of healthcare districts, the rationalization of hospital services, and the development of human resources for health. The project aims to implement an operational strategy to support primary healthcare and promote health and well-being, in line with the strategic objectives, targets, and performance indicators for the healthcare sector.

Results to be achieved:

Result 1 Target healthcare facilities are identified and made structurally and energy efficient.

Result 2: The reference healthcare facilities are equipped with high-quality, nationally standardized electro/biomedical equipment.

Result 3 The national health technical platform is made functional.

List of beneficiaries:

Population of the Congolese territory.

Financing:

Financing worth 45 million euros to be disbursed, in a single solution, through a subsidized loan (35 MEUR) and a grant (10 MEUR).

Description of recent developments*:*

- Interim report of 9 December 2025 of*Groupement AUDITEC-FOIRIER CONSULTING & KPMG CONGO;*
- Draft final report.

· MANAGEMENT PROVISIONS AND WORK PLAN

Desk Analysis	In this first phase, the evaluators will examine the documentation relating to the project. After signing the contract, the DGCS will provide the evaluation team with further documentation relating to the initiative being evaluated. At the kick-off meeting, the team will meet with representatives of the DGCS offices, Agency experts/officials, and other relevant stakeholders.
Inception Report	The team will have to prepare the Initiation Report (see page 9), which will be subject to approval by the DGCS, by the deadline agreed upon during the evaluation kick-off meeting at the DGCS (generally 20 days).
Field visit	In coordination with the Ministry of Foreign Affairs and International Cooperation (MAECI), the Italian Embassy in Brazzaville, and the Italian Agency for International Cooperation (AICS) headquarters in Abidjan, responsible for the Republic of Congo, the evaluation team will visit the initiative sites, interview stakeholders and beneficiaries, and gather all information relevant to the evaluation. The evaluation team will be on site for an estimated total of approximately 20 consecutive days (the actual duration will be determined by the bidder). This period must be covered by at least one mandatory member. The team leader's presence on site, even for a limited period, is encouraged by the assignment of a corresponding score during the technical proposal evaluation (Work Plan). At the end of the field visit, the information gathered for the evaluation will be shared by the team with local stakeholders.
Draft evaluation report	The team will prepare a draft evaluation report, which will be submitted to the DGCS for approval.
Stakeholder comments and feedback	The draft report will be submitted to DGCS internal staff, Agency representatives, and any other stakeholders identified by the DGCS for this purpose. Comments and feedback will be communicated to the evaluators, inviting them to provide any requested clarifications and raise any counter-objections, while fully respecting the independence of the evaluation findings.
Seminar at the DGCS	The DGCS will organize a seminar for the team to present the draft evaluation report and gather any comments and feedback from the parties mentioned in the previous paragraph, which will be useful in drafting the final report.
Final report and additional documentation	The evaluation team, taking into account the comments received, will finalize the final report and submit it to the DGCS for approval. The report may include comments from stakeholders. The ToRs, the complete list of evaluation questions with related indicators and sources, and the list of documents consulted will be attached to the report. The report must also include photographic material and any other documentation produced during the evaluation: questionnaires, specific documents produced for in-depth analysis of particular topics or lines of intervention, secondary information sources used, data collection techniques used in ad hoc surveys, interview organization and execution methods, the definition and quantification methods of the different categories of indicators used, and the procedures and techniques for data analysis and for formulating responses to the evaluation questions, including the Evaluation Matrix, etc.
On-site seminar	The evaluation team, in coordination with the DGCS, will organize a seminar to present the final evaluation report to the stakeholders. The evaluation results will be presented to key local stakeholders: institutional bodies, implementing agencies, beneficiary representatives, etc. The organizational costs of the seminar (including room rental, catering, and any travel reimbursements for local participants) will be borne entirely by the bidder. The basic organizational arrangements for the seminar must be outlined in the bidder's proposal and agreed upon in detail with the DGCS in due time. For the on-site seminar, it is strongly recommended that you provide the “Final Evaluation Report” document translated and printed in the local language.

· FORMAT AND STRUCTURE OF THE EVALUATION REPORT

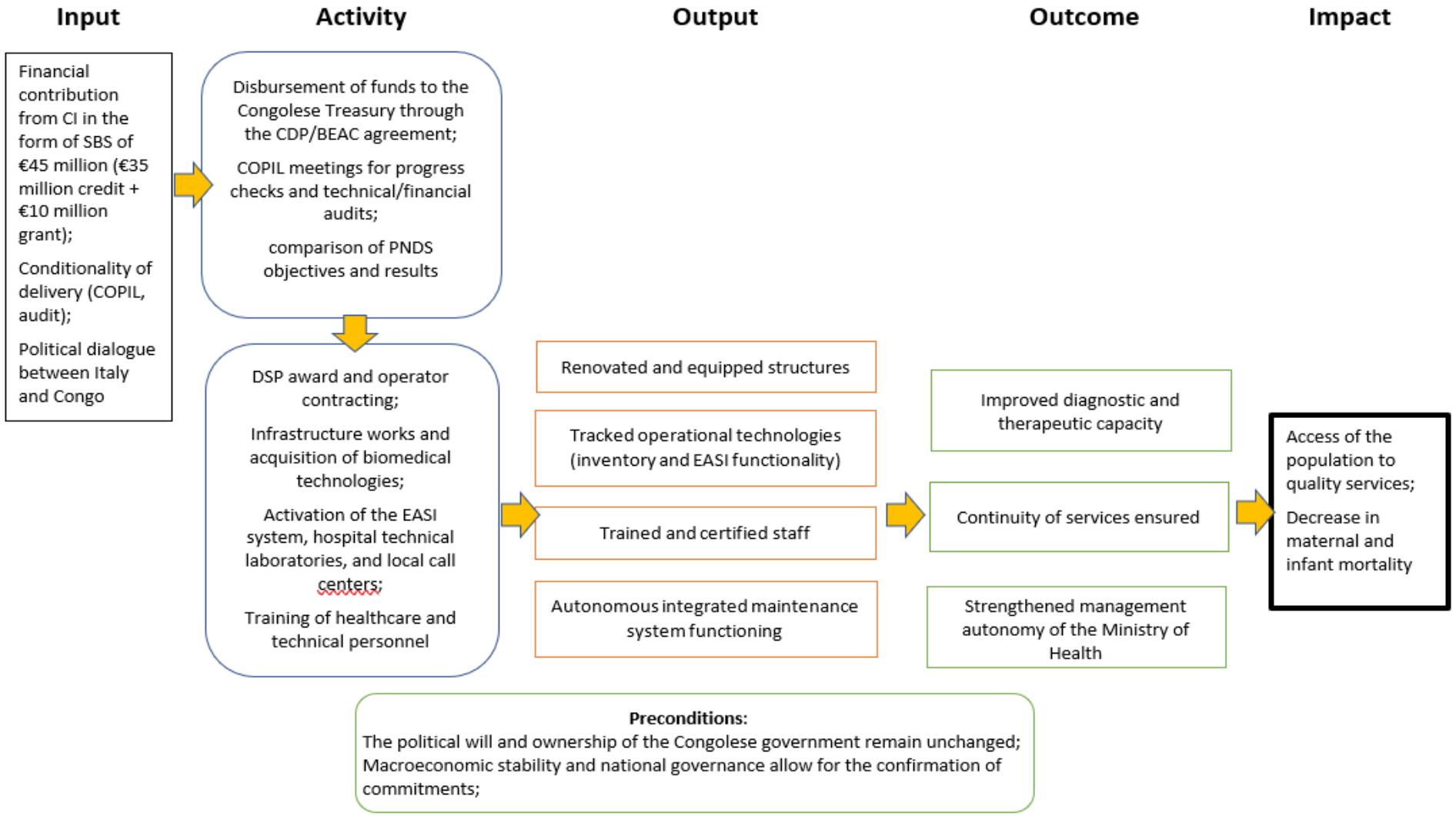
Binding	Paperback with laminated cover featuring the title of the initiative also on the side.
Character	Arial or Times New Roman, size 12 minimum
Cover	The file relating to the first page will be provided by Office VII of the DGCS together with the contents to be included on the first page (award procedure, disclaimer, etc.)
List of acronyms	A list of the acronyms used will be included
Location of interventions	Insert a map of the areas covered by the initiative.
Initial summary	Summary of the context, scope and objectives of the evaluation, data collection and analysis methodology, main conclusions and recommendationsPlease note that a summary version of the final report is available.
Context	- Country situation, based on information collected from accredited international sources. - A brief description of the country's development policies, with particular reference to Italian cooperation, and its political, institutional, socioeconomic, and cultural situation.
Scope and objective	- Description of the initiative being evaluated, including the underlying rationale and strategy, general and specific objectives, expected results, and progress of implementation of individual projects - General and specific objectives of the evaluation.
Theoretical and methodological framework	- The evaluation criteria. - The methodology used and its application, highlighting any difficulties encountered. - Information sources and their degree of reliability.
Presentation of the results	The presentation of the evaluation results must be structured on the basis of the questions formulated by the bidder and the related answers (adequately documented).
Conclusions	The conclusions, based on the evaluation results, will include a clear and reasoned opinion on each of the evaluation criteria and must take into account the requirements of the "Usefulness" section of the ToRs and the cross-cutting themes.
Recommendations	The recommendations, whether related to specific aspects of the evaluated initiative or of a general nature, must be based on the evaluation's findings and conclusions. They are addressed to institutional stakeholders and are aimed at improving Italian cooperation strategies and future projects. To facilitate management response, they should be limited in number (approximately no more than 10 main recommendations) and include a concise formulation that clearly highlights the action to be taken, accompanied by any additional explanatory text.
Lessons learned and best practices	They are based on the findings of the evaluation and can go beyond the narrow scope of the project.
Attachments included in the report	The ToRs (Annex 1), a complete list of evaluation questions with related indicators and sources, and a list of consulted documentation must be included at the bottom of the report. Additional attachments may be included if they do not contain potentially sensitive data (individual names and other information that could be used to identify individuals). The report may also include a list of all additional documentation produced (questionnaires, etc.), including any unattached documentation, always in anonymized form.

ANNEX II – Documentation Consulted

TITLE	AUTHOR/SIGNATORY	DATE
PROJECT DOCUMENTS		
Dossier: SERVICES DE SANTÉ INTÉGRÉS POUR LA REPUBLIC OF THE CONGO	Government of Congo	May 2024
Project Document: Programme de Soutien a la République du Congo pour le Développement aux Services de Santé Intégrés	Ministère de la Coopération Internationale et de la Promotion du Partenariat Publique Privé	June 2024
Request from the partner country	Minister of International Cooperation and Promotion of Public-Private Partnership of the Republic of Congo	September 26, 2024
INFORMATION NOTE FOR THE JOINT COMMITTEE	AICS Management	September 27, 2024
EVALUATION FORM SUPPORT PROGRAM TO THE REPUBLIC OF CONGO FOR THE DEVELOPMENT OF INTEGRATED HEALTH SERVICES	AICS Niamey/Niger	September 27, 2024
Joint Committee Resolution No. 109 of September 30, 2024	MAECI	September 30, 2024
Financial Agreement for the project	Ministère de l'Economie et des finances; Ministère de la Coopération Internationale et de la Promotion du Partenariat Public-Privé de la République du Congo – Cassa Depositi e Prestiti	03/01/2025
Agreement signed: Support program for the Republic of Congo for the development of integrated health services (IT-FR)	Italian Government and Congolese Government	November 25, 2024
Plan de Travail, Chronogramme et détails Financiers Projet Sanitaire	Minister of International Cooperation and Promotion of Public-Private Partnerships of the Republic of Congo	May 2025
Interim Audit Report: EVALUATION DU FINANCEMENT OCTROYÉ PAR LA RÉPUBLIQUE ITALIENNE À LA RÉPUBLIQUE DU CONGO POUR LE RENFORCEMENT DE SON OFFRE DE SANTÉ	Auditec Foirier- KPMG Congo	December 9, 2025
Final Technical and Financial Audit Report: EVALUATION DU FINANCEMENT OCTROYÉ PAR LA RÉPUBLIQUE ITALIENNE À LA RÉPUBLIQUE DU CONGO POUR LE RENFORCEMENT DE SON OFFRE DE SANTÉ	Auditec Foirier- KPMG Congo	March 26, 2026
STRATEGIC REFERENCE MATERIALS		
National Health Policy (PNS) 2018-2023	Government of Congo	2018
NATIONAL POLICY FOR DECENTRALIZATION AND LOCAL DEVELOPMENT	Ministère de l'Intérieur, de la Décentralisation et du Développement Local	July 2017
NATIONAL DEVELOPMENT PLAN 2022-2026	Government of Congo	1.4/01/2022

TITLE	AUTHOR/SIGNATORY	DATE
General Census of Population and Housing (RGPH-5)	UNFPA Congo	2023
Plan National de Développement Sanitaire 2023 - 2026	Ministry of Health and Population - Congo	August 2023
Budget 2024 Ministère de la Santé et de la Population	Ministère de la Santé et de la Population	12/10/2023
Brochure : REVITALISONS LES DISTRICTS SANITAIRES AU CONGO 2me PHASE	Ministry of Health and Population - WHO Congo	May 28, 2024
National Action Plan for Health Security (PANSS)		2024-2028
WHO Cooperation Strategy with Congo 2025 – 2028	WHO Congo	March 2025
WHO Congo Annual Report 2025	WHO Congo	April 2026
Budget 2025 Ministère de la Santé et de la Population	Ministère de la Santé et de la Population	26/05/2025
Arreté de Decoupage de Districts Sanitaires	Ministère de l'Intérieur e de la Décentralisation	March 17, 2026
Budget 2026 Ministère de la Santé et de la Population	Ministry of Finance	March 31, 2026
REPORT OF MEETINGS AND CONFERENCES		
Reports of the Steering Committee Meetings (COPIL)	Members of COPIL	June 9, 2025 November 18, 2025 December 22, 2025 February 22, 2026
AICS Mission Reports in Congo	AICS Abidjan	November 2025 January 2026
REPORT OF THE REVIEW OF MI-PARCOURS DES ACTIVITÉS DES HÔPITAUX 2026 « Consolidation of the offer and access to quality products »	MINISTÈRE DE LA SANTÉ ET DE LA POPULATION DIRECTION GENERAL OF SOINS AND SERVICES DE SANTÉ. DIRECTION DES HÔPITAUX	July 14-17, 2026

ANNEX IV – Theory of Change



ANNEX V – Evaluation Matrix

CRITERION	EVALUATION QUESTIONS AND SUB-QUESTIONS	INDICATORS	SOURCES
Relevance	**DV1.**To what extent did the decision to intervene in 9 hospital facilities with an integrated technological management model respond to the priority diagnostic and therapeutic needs of the Congolese healthcare system?	•	
	- Did the three pillars of intervention (technological modernization, training, integrated maintenance) correspond to the most critical deficiencies of the target hospitals? - Was the DSP approach appropriate to the Congolese institutional context, or were there more effective alternatives?	Degree of correspondence between intervention areas and gaps identified in the PNDS 2023-2026 (qualitative scale) Number of priority clinical areas of the PNDS covered by the intervention	PNDS 2023-2026 Althea Work Plan (assessment of needs for the facility) Semi-structured interviews with MSPs and hospital management
	DV2. To what extent was the intervention design aligned with national health policies (PNDS 2023-2026), the WHO strategy (13th GPW) and SDGs 3.1, 3.2 and 3c?		
	- Did the program contribute to strengthening the second phase of the national strategy for the revitalization of advanced health services? - Were vulnerable groups (women, newborns, geographically disadvantaged areas) explicitly included in the design?	Number of PNDS objectives formally referred to in the Financing Agreement Presence of indicators disaggregated by gender and geographical area in the Logical Framework (yes/no) % of target facilities in areas with low health coverage	Financing Agreement Nov. 2024 WHO/World Bank documents on the Congolese health system AICS Evaluation Form
Consistency	**DV3.**Is the DSP model with a private operator consistent with the Congolese regulatory framework and with the Italian Cooperation policies regarding public-private partnerships in healthcare?		

	- Was the use of the Public Service Delegation discussed and agreed upon with the Italian Government when the initiative was approved? - Have tensions emerged between the logic of BSS (government ownership) and the logic of DSP (private management with KPIs)?	▪ Presence of formally documented MCIPPPP-MSP coordination mechanisms ▪ No. of COPIL meetings actually held vs. expected ▪ Operation of the COPIL supervision system	COPIL Minutes MCIPPPP-Althea Contract Interviews with MCIPPPP and MSP
	DV4. Were duplications with other donors active in the Congolese health sector (EU, World Bank, WHO, UNICEF) avoided and available synergies maximized?		
	- What coordination mechanisms have been adopted with AICS Abidjan, the Italian Embassy in Brazzaville, and the main international partners? - To what extent has Phase I of the Italian program been coherently integrated into the second phase of the WHO strategy for the revitalization of health districts?	Number of overlaps identified with other similar interventions No. of coordination agreements formalized with other donors % synergistic activities compared to total	Database of active donors in Congo (OECD-DAC, UN-OCHA) WHO/UNICEF action plans on the ground Interviews with AICS Abidjan and the Italian Embassy
Effectiveness	**DV5.**To what extent have the 9 target hospital facilities been equipped with functioning biomedical technologies, with adequate infrastructure works and an operational EASI system?		
	- What is the actual condition of the equipment planned for installation? - Is the EASI traceability system operational in all facilities or only in some? - Have the local technical laboratories and call centers been activated as planned?	% of equipment installed and functioning / total delivered (target: ≥90%) Average uptime of critical equipment (contractual target: 96%) Number of facilities with operational EASI system (target 9)	EASI system log KPMG Interim and Final Report Direct observation in the sampled structures
	DV6. To what extent have trained healthcare and technical personnel acquired effective skills in the use, management, and maintenance of biomedical technologies?		

	- Was the target of 75% of staff with improved skills achieved not only in quantitative terms (% trained) but also in qualitative terms (quality of transfer)? - Has the training model generated the ability to "train the trainers" (internal multiplier)?	▪ % trained staff / total target (target: ≥75%) ▪ Pre/post training competency test results ▪ Number of local biomedical technicians able to operate independently on the main equipment	▪ Training records ▪ Semi-structured interviews with trained staff ▪ Focus groups with technical staff in the visited facilities
Efficiency	**DV7.**To what extent has the Sector Budget Support mechanism functioned as a policy dialogue tool, guiding the Congolese government's decisions towards measurable health outcomes beyond simple documentary compliance?		
	- Did the Agreement's conditionalities (Articles 5.3 and 5.4: >50% spent and >70% committed for the second tranche) have an additional effect on the quality of implementation? - Did the bilateral political dialogue impact the allocation decisions of the MCIPPP and the MSP? - Were the BSS funds managed transparently, traceably, and with accounting separation between the two components?	Timing of compliance with conditionalities (ex-ante and ex-post) Change in the 2024-2025 MSP healthcare budget allocation (additionality vs. fungibility effect) Quality of political dialogue: number of formal interactions between Italy and Congo beyond COPIL Existence of separate accounts for credit and gift components	Financing Agreement, art. 5.3-5.4 MSP Budgets 2024-2025 COPIL minutes and AICS-MCIPPPP correspondence KPMG Interim Report and Final Report
	DV8. Did the management, supervision, and procurement mechanisms comply with the principles of cost-effectiveness, transparency, and timeliness?		
	- Did COPIL exercise an effective supervisory role or did it remain a predominantly formal body? - Were the approved schedule met?	Deviation between expected and actual schedule (weeks of delay per phase) Number of COPIL meetings held/planned and quality of decisions taken Administrative audit results 2025	COPIL Minutes Work Plan Timeline Administrative Audit Report 2025
Impact	**DV9.**What significant effects—both expected and unexpected—has the program had on the		

	Congolese health system's capacity to provide advanced diagnostic and therapeutic services?		
	- To what extent did the intervention contribute to reducing the use of foreign facilities or healthcare migration for services not available locally? - Have spillover effects been recorded on structures that are not directly beneficiaries?	Change in maternal and child mortality rate in intervention areas (SDG 3.1, 3.2) Number of previously unavailable advanced diagnostic services activated in the target facilities	MSP and WHO/Congo Statistics World Bank Reports on the Congolese Health System 2024-2025 Interviews with local operators and WHO Brazzaville
	DV10. To what extent has the program contributed to reducing disparities in access to health services, with attention to gender, minors, and populations in underserved areas?		
	- Did the geographical distribution of the 9 facilities ensure equitable access for the populations of the inland regions? - Have obstetrics, neonatology, and pediatric services seen specific improvements?	% of female and minor beneficiaries compared to the total number of users of the target facilities Changes in access to maternal and child services in remote area facilities Presence of financial, linguistic or geographical barriers to accessing services	Activity records of obstetrics/neonatal/pediatrics departments by facility Focus group with patients and companions Gender-disaggregated data from the EASI system
Sustainability	**DV11**Are the financial and institutional conditions in place to ensure the continuity of the program's benefits after the Italian funding ends?		
	- Has the Congolese government allocated its own funds for equipment maintenance in the 2026-2027 budget? - Has the financing model envisaged by the DSP actually been activated?	MSP budget allocation for biomedical technology maintenance 2026-2027 (€ or % of total) Level of perceived local ownership (scale 1-5) No. of institutional strategic plans integrating the program results	Congo Budget Law 2026 MEF-Congo Interviews Focus group with hospital management

	DV12. To what extent do the results of Phase I provide a reliable and scalable evidence base for funding and designing Phase II?		
	- Can the DSP model be replicated at a larger scale while maintaining the performance levels achieved in Phase I? - Are there any systemic risks identified in the design of the first phase that could jeopardize the continuation of the initiative?	Identification of 3-5 critical enablers for model scalability Identification of 3-5 systemic risks requiring mitigation in Phase II Availability of sufficient quantitative evidence to support the funding decision	Comparative Analysis Phase I vs. Phase II Objectives KPMG Final Report Interviews with MAECI-DGCS and AICS on expectations for Phase II

ANNEX VI – Stakeholder Interview Outline

QUESTIONNAIRE FOR STAKEHOLDERS

(HDP (WHO, EUD, UNDP, UNFPA, UNICEF, UNHCR, IOM, GAVI, etc.) Line Ministries, etc.)

Date

Entity ……

Function …….

Location ……..

4.1 Are you familiar with the project “Support Program for the Republic of Congo for the Development of Integrated Health Services” funded by Italian Cooperation?

4.2 When was it introduced to you?

4.3 Was there an official presentation or inauguration of the project?

4.4 By whom and where was it organized?

4.5 What was your role in this project?

4.6 What is your mandate in the health sector in the country?

4.6 Has the evaluation of the PNDS 2023-2026 been carried out?

4.7 Can you share the report?

4.8 What are the strong and weak aspects of the past PNDS?

4.9 What are your priorities for the new PNDS?

4.10 Has the new PNDS already been developed?

4.11 Who participated or is participating in the development of the new PNDS?

4.12 How is the health system organized in Congo?

4.13 Who from Italian Cooperation participates in the HDP meetings?

4.14 When we talk about integrated health services, what does it mean in Congo?

4.15 What aspects would you recommend funding for the new PNDS?

