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Impact Evaluation – CONGO

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

AID 13158



PROJECT IDENTIFICATION DATA	
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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
TFP	Technical and Financial Partner
ToC	Theory of Change
ToR	Terms of Reference
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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1. CONTEXT

The Republic of the Congo covers 342,000 square kilometers and has, according to the 2023 RGPH-5 census, a population of 6,142,180. The population is predominantly female (50.3%) and very young (75.3% under 35 years of age) and has an annual growth rate of 3.2%. Life expectancy at birth in 2022 was 63.05 years, and the population is highly concentrated: Brazzaville and Pointe-Noire are home to 58.2% of the population, with extremely uneven population densities between urban and rural areas. On the economic level, in 2022 the GDP per capita was around 2,520 USD (lower-middle income economy) and in 2023 the Human Development Index was 0.593 (149th place out of 193 countries), in a context marked by high unemployment (around 22%, 42% youth unemployment), poverty at 52.5% (2020) and persistent territorial and social inequalities in access to essential services.

The right to health is enshrined in the Constitution of October 25, 2015, and supported by the Universal Medical Assistance Regime (RAMU), established by Law No. 37-2014 and updated by Law No. 12-2023. Despite the decentralization initiated by Law No. 10 of 2003, the health system continues to be characterized by regional and socioeconomic disparities, particularly between rural and urban areas, with repercussions on provision, access to services, and public health. The healthcare system is organized according to a three-tier pyramid structure (échelons), defined by the PNDS 2023-2026 and Presidential Decree No. 551 of October 15, 2020. The first level, dedicated to primary care, is provided by the Integrated Health Centers (CSI), along with dispensaries and outpatient facilities, with community participation through COGES and COSA. The second level consists of the District Reference Hospitals (HRD), which serve as a point of reference for the CSI and are the cornerstone of the Health District, with missions defined by Decree No. 2020-552 (quality care, maternal and child health, continuity and referral of care, public health, training and monitoring). The third level includes the departmental General Hospitals (HG) and the facilities under the direct supervision of the central level, with tertiary function and supervision by the Minister's Office.

The strategic framework is defined by the National Health Policy (PNS) 2018-2030, which aims to create an efficient and resilient healthcare system capable of ensuring universal access, operationally translated into the National Health Development Plan (PNDS) 2023-2026. In recent years, the government has strengthened the regulatory framework with new decrees on the organization of the Ministry of Health and Population (MSP), the adoption of fifteen laws on general hospitals, and the division of the country into 52 health districts. However, shortcomings remain, particularly the inadequacy of the PNDS's implementing texts and delays in implementing the new MSP structure.

Significant progress has been made in managing health emergencies, with improvements in capacity indicators (from 44% in 2017 to 54% in 2019), protection and preparedness, and the implementation of national health security plans (PANSS). However, significant challenges remain: limited mobilization of domestic resources, insufficient surveillance capacity, an incomplete event-based system, limited capacity at points of entry, and the inoperability of the national laboratory network.

Decree No. 2024-2696 of November 18, 2024, established a national "One Health" platform, while several ministries are working on the social determinants of health. As part of the 2023-2026 PNDS, the MSP has intensified advocacy for the health SDGs and the commitments of the Abuja Declaration (15% of the national budget for health), in line with the principle of efficient and responsible resource management. Congo is supported by a broad technical and financial partnership (PTF): UN agencies (WHO, UNICEF, UNFPA, WFP, UNHCR, UNDP, UNESCO, FAO, UNAIDS), multilateral institutions (World Bank, Gavi, Global Fund, European Union), bilateral cooperation (France, Russia, United States, China, Italy), and NGOs, with WHO providing advice and facilitating policy dialogue at the MSP.

2. SCOPE OF EVALUATION

The AID 013158 program was developed based on a request from the Congolese government and the Project Document submitted by the Ministry of International Cooperation and the Promotion of Public-Private Partnerships (MCIPPPP). The initiative, classified as untied bilateral aid, had a planned duration of 36 months and a total budget of €45 million, consisting of a concessional loan of €35 million and a grant component of €10 million.

The overall objective of the program. The aim was to contribute to improving access to and expanding coverage of healthcare services for the population of the Republic of Congo. This was linked to the specific objective of upgrading the country's healthcare facilities to a higher standard of performance. The intervention was structured around three expected outcomes and four complementary axes: infrastructure upgrades and improved hydro-energy efficiency; maintenance, replacement, and acquisition of biomedical equipment; ongoing training for technical and healthcare personnel; creation or strengthening of local technical-managerial structures and a central digital coordination center for the management and maintenance of the technical platform.

The chosen financing method was sector budget support (SBS), through which resources are transferred directly to the Congolese state budget for the health sector. This method aims to enhance the principle of ownership, assigning the national counterpart responsibility for the planning, management, and use of resources, consistent with the sector's strategic plans. The implementing entity is the MCIPPPP, which has decided to avail itself, in accordance with Congolese legislation, of a Public Service Delegation (PSD) to assign the procurement of goods and services to a specialized operator.

The model was designed with sustainability and replicability in mind. Staff training, the development of local expertise in biomedical engineering, and the establishment of a centralized system for managing the technical platform should progressively increase the autonomy of the Ministry of Health and healthcare facilities in managing and maintaining the equipment. At the same time, the experience gained in the initially selected facilities should provide an operational and knowledge base for extending the model to other facilities and areas of the country.

The project formally launched on July 15, 2025. The intervention involved six general hospitals (Adolphe Sice, Blanche Gomez, Loandjili, Dolisie, 31 Juillet d'Owando, and Edith Lucie Bongo Ondimba/Oyo) and three secondary facilities: Makélékélé, Talangaï, and the National Blood Transfusion Center (CNTS). The May 2025 Work Plan limited the technical interventions to a few priority departments, such as intensive care, the operating room, neonatology, and the emergency room, rather than envisioning the overall adaptation of the facilities.

The evaluation, designed according to OECD-DAC criteria, was required not only to report on the results achieved but also to produce evidence useful for guiding decisions on possible subsequent phases. The analysis therefore focused on the effectiveness of the intervention and the initial effects on hospitals' ability to provide quality services; the sustainability of the technical and organizational solutions introduced; consistency with Congolese healthcare policies, the priorities of Italian Cooperation, and the interventions of other partners; as well as the adequacy of the SBS approach in terms of governance, expenditure traceability, conditionality, and efficiency. The evaluation also had to identify the enabling factors and risks associated with the continuation of the program, and its replicability and scalability, producing conclusions and recommendations useful for future programming by the Ministry of Foreign Affairs and International Cooperation (MAECI-DGCS), including within the framework of the Mattei Plan for Africa.

3. THEORETICAL AND METHODOLOGICAL FRAMEWORK

3.1. Methodological framework

The evaluation was conducted in accordance with the 2019 OECD-DAC criteria, the DGCS Guidelines for the Impact Evaluation of Development Cooperation Interventions, and the principles of utility, credibility, independence, impartiality, transparency, and ethics. The process adopted a utilization-focused approach, aimed at producing reliable evidence on the results of the first phase and the conditions necessary to guide the decision regarding the possible financing of a second phase, formally requested by the Congolese government.

The methodological framework integrated three complementary approaches. The Results-Based Approach was used to analyze evidence regarding the Logical Framework's outputs and outcomes, while the Theory-Based Approach allowed us to examine the causal hypotheses underlying the intervention design and verify the validity of the Theory of Change. A three-step approach was also adopted to analyze sector budget support, based on contribution analysis of the relationship between inputs and outputs, attribution analysis of the relationship between outcomes and impact, and a subsequent integrated analysis.

The Theory of Change developed during the initiation phase was critically assessed through documentary analysis and a field mission, distinguishing confirmed from unverified hypotheses and identifying the contextual factors that influenced the causal chain. Particular attention was paid to the relationship between the integrated management model based on Public Service Delegation and the actual capacity of healthcare facilities to develop lasting autonomy in the management and maintenance of biomedical technologies. The evaluation questions were then structured around the six OECD-DAC criteria, with a particular emphasis on impact and sustainability, given the prospective function of the evaluation.

3.2. Evaluation phases

The process was divided into three phases: initiation, data collection and analysis, and report drafting. The initiation phase, which took place between June and early July 2026, included the kick-off meeting on June 18 at the Ministry of Foreign Affairs and International Cooperation in Rome, preliminary interviews with the Italian Agency for Development Cooperation (AICS), the Italian Embassy in Brazzaville, and several local stakeholders, as well as an initial review of available documentation. Based on the information gathered, the main information gaps were identified, the operational and logistical conditions of the mission were defined, and the Initiation Report was prepared, which was submitted on July 1 and approved on July 8, 2026.

The field mission took place from July 5 to 19, 2026, and involved healthcare facilities in Brazzaville, Pointe-Noire, Oyo, and Owando. The visits, interviews, and group meetings were conducted using semi-standardized guidelines, adapted to the different stakeholder groups. The mission was partially conducted in parallel with the final monitoring by AICS and concluded with a preliminary feedback

session with local stakeholders and the submission of a summary note on initial findings to the Ministry of Foreign Affairs and International Cooperation. The reporting phase, conducted between August and September 2026, included the preparation of the interim report, the discussion of the Client's observations, and the subsequent finalization of the document.

3.3. Data collection and analysis methods

The evaluation adopted a mixed-methods design, combining quantitative and qualitative data and primary and secondary sources. The specific nature of the Sectoral Budget Support, implemented through a Public Service Delegation, required a separate analysis of the management of resources transferred to the Congolese state budget and the production of technical outputs, which were entrusted to a private operator with no direct contractual relationship with the Italian donor.

The collection strategy was affected by the lack of a formalized baseline, the ineffectiveness of the Technical Monitoring Committee, and critical issues related to financial traceability, particularly the accounting separation between credit and donations and payments made by the operator to subcontractors. To address these shortcomings, the evaluation gradually built convergent evidence, subjecting it to systematic triangulation. The initial situation was reconstructed, to the extent possible, using data from the National Health Information System, the PNDS 2023-2026, the WHO, and the World Bank, supplemented with more recent documents.

Desk analysis. The analysis involved official project documents, materials produced by various stakeholders during implementation, and national and international regulatory and strategic documentation. However, it was not possible to reconstruct a sufficiently reliable baseline for a counterfactual analysis due to the heterogeneity of the sources, the lack of disaggregated data for the individual departments of the nine facilities, the poor correspondence between available data and the Logical Framework targets, and the impossibility of accessing the initial inventory data and the EASI system reports. Similarly, the unavailability of the complete contract between MCIPPPP and the private operator and the related management data prevented a full assessment of the contractual performance of the PSD model.

Field analysis. Collected primary evidence through direct observations, semi-structured interviews, and group meetings with healthcare and technical staff, patients, caregivers, and civil society representatives. The visits inspected equipment installation areas, hospital technical laboratories, infrastructure upgrades, and the availability of operational and maintenance documentation. Interviews involved bilateral and healthcare governance stakeholders, hospital management, and department staff. Discussions with WHO, UNFPA, the Global Fund, and the World Bank further explored external coherence and potential synergies or overlaps with other interventions.

Finally, the methodological framework had to take into account the predominantly implementation- and process-related nature of the indicators and the significant reduction in implementation times compared to the three-year timeframe envisaged. These conditions limited the ability to measure structural changes in diagnostic and therapeutic capabilities or medium-term effects on health and access to care. The evaluation therefore adopted a predominantly qualitative approach, oriented toward analyzing the functionality of the implemented solutions, stakeholder perceptions, and initial signs of change, rather than rigorously measuring the counterfactual impact.

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?

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 three pillars of the intervention (technological modernization, training, and integrated maintenance) are overall adequate to address the main critical issues facing the Congolese hospital system identified in the Project Document and the PNDS 2023-2026: obsolescence and malfunctioning of equipment, insufficient spare parts, limited asset traceability, and a lack of skills for their use and maintenance. The program addressed these issues through the replacement and installation of biomedical technologies, staff training, and the creation of maintenance centers and computerized management systems.

The overall relevance of the approach, however, was undermined by the limited presence of a participatory and documented process for selecting facilities and defining priorities at the individual hospital and department level. The limited involvement of hospital management and staff resulted, in some cases, in the introduction of supplies in less than fully adequate settings. Training also focused primarily on the use of equipment, without sufficiently addressing internal staff maintenance skills and the clinical appropriateness of diagnoses aided by new technologies.

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

The Public Service Delegation is not inappropriate in principle: it is compatible with the Congolese regulatory framework, leverages the country's previous experiences, and has enabled the rapid mobilization of specialized skills, standardization of supplies, and improved continuity of technical interventions. However, the model actually applied has characteristics closer to a global service contract than to a PSD in the strict sense, since the operator is remunerated through a fixed fee financed by public resources, rather than based on service performance and the assumption of the related operational risk.

The main criticality lies in the overlap between the Sector Budget Support approach and management that is effectively similar to that of a traditional project entrusted to a private operator. The limited involvement of the Ministries of Health and Finance and their respective technical directorates has effectively weakened institutional ownership, while the transfer of expertise to local technicians has remained partial, generating sustainability risks. There is no evidence that an alternative model would necessarily have been more effective; rather, it would have been necessary to better integrate SBS and PSD, clarify roles and responsibilities, and establish a verifiable path for public ownership of expertise and maintenance systems.

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?

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 is substantially consistent with the PNDS 2023-2026, although the definition of a "second phase of development of advanced healthcare services," used in the Project Document, is not formally reflected in the National Plan, which organizes interventions into programs and subprograms implemented simultaneously at different levels of the healthcare system. The reference to Actions 1, 5, and 8 of Subprogram 3.1 also appears only partially relevant, as the first two primarily concern healthcare districts and second-level referral hospitals. The initiative, however, is directly attributable to Action 6, dedicated to the maintenance and development of General Hospitals, and addresses the technical equipment and maintenance gaps identified by the PNDS.

The intervention also complements the WHO Cooperation Strategy for Congo 2025-2028. While WHO's operational efforts focus primarily on revitalizing health districts and primary care, the Italian program strengthens the hospital and tertiary care component, which falls under the direct responsibility of the central level of the Ministry of Health. The program therefore follows WHO's efforts, following the logic of the national health pyramid; however, this complementarity is primarily strategic and document-based and does not correspond to a formalized two-phase sequence within the PNDS.

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

The inclusion of vulnerable groups in the intervention design is partialand not based on explicit criteria. The selection of facilities favored Brazzaville and Pointe-Noire, where the majority of the population is concentrated, rather than remote and geographically disadvantaged areas. Although the project included interventions in maternity, neonatology, and operating rooms, maternal and neonatal health was not considered a cross-cutting priority, and the relevant departments of the Ministry of Health, hospitals, and specialized partners (UNFPA, WHO, and the World Bank) were not systematically involved in the initial needs assessment.

The project also failed to include complementary measures to facilitate access to hospitals for the most isolated populations, such as medical transport systems, referral networks from peripheral centers, or waiting centers for women with high-risk pregnancies. Therefore, women and newborns may benefit indirectly from strengthening certain facilities, but the plan cannot be considered explicitly oriented toward vulnerability, territorial equity, or overcoming the access barriers that affect rural and remote populations.

4.2. Coherence

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

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 use of the Public Service Delegation (PSD) does not appear to have been formally discussed or agreed upon with the Italian Government during the initiative's approval process. The Joint Committee Resolution, the DGCS Information Note, and the Intergovernmental Agreement describe the intervention as sector budget support and grant the Congolese counterpart autonomy over implementation methods, without specifically mentioning the PSD. Although the Congolese Project Document and funding request indicated the PSD as the preferred method, the related contract, operator selection procedure, and regulatory framework were independently defined by the Congolese Government and were not submitted to the AICS for negotiation or validation.

The lack of prior coordination between the Italian financing documents and those relating to the PSD has led to differences in interpretation regarding the program's duration, objectives, and activities. The original proposal envisioned a five-year timeframe, the Financial Agreement set a disbursement deadline of 36 months, and the Work Plan, while calling for a 36-month duration, described activities and expenditures for the first five years. The PSD was therefore assumed by the Italian side as an implementation method already defined by the other side, without being specifically integrated into the initiative's programmatic and financial framework.

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

Difficulties arose in reconciling the logic of Sectoral Budget Support, based on the ownership and responsibility of Congolese public institutions, and that of the PSD, based on a contractual relationship with a single private operator remunerated through lump sum payments. The timing, procedures, and reporting systems of the two mechanisms were not synchronized, while the Steering Committee primarily validated the auditor's reports ex post, lacking an integrated framework linking the SBS conditionalities to the contractual objectives and indicators of the PSD.

This separation was particularly evident in financial management and monitoring: the audit verified the compliance of performance with the Work Plan, in accordance with the PSD logic, without linking these results to the conditionalities inherent in budget support. The tensions did not impede the technical implementation of the planned activities, but they highlighted a deficit in institutional planning. Combining the two instruments would have required, from the moment of approval, a unified programming, supervision, and reporting system capable of reconciling public ownership, financial conditionalities, and private operator results.

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

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

Coordination mechanisms were largely limited to Steering Committee meetings and were not fully adequate to the complexity of the intervention. The transfer of responsibility from the AICS headquarters in Niamey to Abidjan after the project's launch limited the continuity of technical support: AICS Abidjan participated in some visits and in the Steering Committee (COPIL), but did not provide ongoing operational supervision, partly because the initiative was formally considered

budget support, which was the sole responsibility of the Congolese government. The Italian Embassy in Brazzaville ensured effective diplomatic support and facilitated communications, but the lack of a stable AICS technical structure in the country reduced the ability to regularly monitor the start-up phase and equipment delivery.

Coordination with Congolese institutions and international partners was also limited. The Ministry of Health's technical directorates and hospital directors were only marginally involved, while WHO, UNFPA, and other partners received mostly fragmented information. Of particular note is the lack of coordination with the World Bank, which had purchased equipment for some of the same facilities, creating a real risk of duplication and preventing the exploitation of potential synergies in supplies, maintenance, and training.

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?

Phase I of the Italian program is strategically complementary to WHO's efforts, but cannot be considered an operationally integrated component of the revitalization of health districts. WHO primarily intervenes at the first two levels of the healthcare pyramid (Integrated Health Centers and District Reference Hospitals), strengthening primary care, community participation, and maternal and neonatal health. The Italian program, on the other hand, focuses on the third level, consisting of General Hospitals under the central level's responsibility. The two interventions therefore share the general guidelines of the PNDS 2023-2026, universal health coverage, and SDG 3, but operate at different institutional and functional levels.

The lack of a structured dialogue between the Italian program and the WHO has prevented this strategic complementarity from being transformed into operational synergies. Systematic connections between general hospitals and the district network have not been developed, nor have joint initiatives been developed on community participation, maternal and neonatal health, drug management, vaccination, or local referral mechanisms. Duplication cannot therefore be completely ruled out, and opportunities for integration with the WHO program and other partners have not been sufficiently exploited.

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?

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

The planned supplies are substantially completed. The final audit report certifies that the equipment has been installed, verified, inventoried, and registered in the management system; the 45 technologies that were listed as delivered but not yet installed in the interim report have since been implemented. Overall, the EASI system records 5,969 devices, including those supplied by the program and pre-existing ones entrusted to the integrated management service.

However, installation does not always coincide with full clinical operation. In the intensive care units at Makélékélé, Talangaï, and Adolphe Sicé, some technologies were not fully usable due to the lack of connection to medical gas networks. Additional infrastructure issues included oxygen production at Dolisie, radiation protection systems at Adolphe Sicé, and the elevator and air conditioning at

Loandjili. Although these interventions were outside the scope of the PSD, their lack of prior verification delayed the commissioning of some of the equipment and reduced its potential use.

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

According to the final audit report, EASI is active in the eight hospitals included in the contractual scope, and access has been assigned to the technical focal points of the facilities and the Ministry of Health. The CNTS is the only exception: due to the limited size of its technological facilities and the lack of suitable space, equipment management and traceability are ensured through the Blanche Gomes Maternity and Children's Hospital system.

However, field evidence paints a less consolidated picture. The platform is still primarily managed by the private operator, while hospital staff have limited involvement in its actual management and access to technical documentation. Because the Evaluation Team did not have direct access to the system and its logs, it was not possible to independently verify data quality, fault resolution times, equipment availability, and the actual level of ownership of the tool by Congolese institutions.

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

The technical laboratories and call centers are generally activated and functioning. The assessment mission verified the rehabilitation of the premises, the availability of key maintenance components, and the operational functionality of the request processing systems. Two organizational exceptions remain: the CNTS is covered by the Blanche Gomes laboratory, while the Loandjili laboratory is not yet fully operational and is temporarily supported by the Adolphe Sicé laboratory.

The main criticality concerns the sustainability of the model. Laboratory staff are almost entirely dependent on the private operator, and there is no defined mechanism for their progressive transfer to hospitals or the Ministry of Health. The laboratories, dedicated technicians, and the EASI platform therefore operate as a parallel infrastructure to the ministerial training and maintenance system, limiting public ownership and the continuity of services after the conclusion of the PSD.

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

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)?

Achieving the target of 75% of staff with improved skills is not verifiable. The project did not produce the initial assessment necessary to define the baseline, and the results of the post-training tests required by the Logical Framework are not available. Interviews indicate that maintenance activities continue to be performed primarily by technicians from the private operator; local staff participate in the support, but there is no documented evidence of the level of autonomy achieved. The positive evaluations expressed by hospital management primarily concern the professional quality of the private operator's technicians, not the actual transfer of skills to hospital staff.

Furthermore, the training focused primarily on the use and maintenance of equipment, without including a clinical component aimed at improving diagnosis and treatment. Concentrating the activities into approximately six months further limited the opportunity to consolidate and verify the acquired skills:

effective transfer of know-how requires extended support, supervised practice, and progressive assessment of autonomy. The evidence collected therefore indicates a training process that is well-established and appreciated, but still partial and insufficiently documented to demonstrate the quantitative and qualitative achievement of the target.

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

The model has not yet generated a structured capacity to "train the trainers". On-the-job training between operator technicians and local staff is a promising practice, but it remains based on direct transfer between trainer and trainee and does not involve local figures formally qualified to train new staff. Therefore, the transfer of skills is still ongoing and has not developed into a multiplier mechanism capable of spreading independently within hospitals or to other facilities.

The project lacks a formalized curriculum, certifications, dedicated local trainers, or a structured mentoring and coaching system. Building such capacity would require integration with the national human resources policy and partnerships with organizations such as UNESCO, the WHO, and Congolese vocational training institutions. The lack of an organized supply chain for spare parts and shared contacts with suppliers also limits the technicians' future autonomy. The model therefore offers significant potential, but requires institutionalization, resources, and more time to generate effective internal multipliers.

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?

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 conditionalities required for the disbursement of the second tranche (at least 50% of the first tranche spent and at least 70% formally committed) had an additional effect, especially on the speed of implementation and the discipline of financial reporting. The thresholds incentivized the operator to rapidly mobilize its logistical capabilities, helping to accelerate the supply and installation of equipment. However, the mechanism was exclusively quantitative and financial and measured the capacity to absorb resources, without considering the technical quality of the projects, their correspondence to healthcare needs, or institutional strengthening.

The lack of parallel indicators relating to sustainability, skill transfer, and capacity building within the Ministry of Health therefore constitutes a structural limitation. Conditionalities have promoted compliance and speed of spending, but have not directly guided the program toward measurable health outcomes. This would have required a technical monitoring system linked to the disbursement of tranches, which the planned Technical Monitoring Committee was unable to perform, as it had not been established.

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

Bilateral political dialogue strengthened formal alignment with the PNDS 2023-2026, the initiative's visibility, and relations between Italy and the Republic of the Congo, but had a limited impact on operational allocation decisions. The decision on priorities, facilities, supplies, and implementation methods remained largely in the hands of the MCIPPPP, while the Ministry of Health, its technical directorates, and hospitals had a more limited involvement. Italian funding therefore primarily represented an additional resource, without profoundly altering sector governance.

The Italian institutional missions contributed to the program's political legitimacy and accelerated the Congolese request for a second phase, but they did not generate effective co-decision on health priorities and resource allocation. The persistent communication difficulties between the MCIPPPP, the Ministry of Health, and hospital management demonstrate that the policy dialogue was not supported by a technical, structured, and documented mechanism capable of guiding implementation and guiding decisions toward shared health outcomes.

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

The final audit report confirms the accounting separation between the €35 million concessional loan and the €10 million grant component. The reconciliation of disbursements, bank records, operator transfers, and invoices revealed no unjustified discrepancies, confirming the traceability of flows back to the operational beneficiary. However, this assessment offers a reasonable, but not absolute, level of assurance: checks on supplier payments were conducted on a sample basis, and the final report focused on the formal consistency of the flows, without repeating the in-depth analysis of financial appropriateness previously conducted.

Furthermore, the separation between credit and grants remained limited to the level of financial flows and did not translate into a separate attribution of expenses and results. The lump sum payment provided by the PSD cumulatively includes supplies, maintenance, and training, without allowing for the identification of which component financed each activity. It is therefore impossible to isolate the specific contribution of the grant to capacity building, nor to separately account for the results achieved through non-reimbursable resources.

Q.8. Did the management, supervision, and procurement mechanisms comply with the principles of cost-effectiveness, transparency, and timeliness?

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

COPIL did not remain a merely formal body: validated the audit documents and formulated specific technical findings regarding the segregation of funds, infrastructure upgrades, the connection of medical gases, the procurement of spare parts, staff training, and the involvement of hospital management. Its action was, however, hampered by the lack of a unified monitoring framework. The AICS Logical Framework, the generic indicators of the Project Document, and the PSD KPIs were not coordinated, while the planned initial assessment was not carried out.

Furthermore, the Work Plan contained activities and expenditures, but no verifiable performance indicators.

COPIL's ability to translate its observations into corrective actions remained limited. As of February 2026, several critical issues reported three months earlier remained unresolved, resulting in delays in the full commissioning of the equipment. The Committee itself recognized the need for more effective oversight tools and proposed a Technical Monitoring Committee, which appears not to have been activated. COPIL thus exercised substantial oversight in terms of analysis and reporting, but less effectively in terms of verifying corrective actions and their timely implementation.

D.8.2 Were the approved timetable deadlines respected?

Timelines must be assessed by distinguishing the Work Plan for the first year from the broader program horizon. The original Congolese proposal envisaged five years, the Italian Financial Agreement a disbursement period of 36 months, while the Work Plan only detailed the first year. This overlapping timeline resulted in an implicit redefinition of the intervention in subsequent phases, without a clear shared formalization, generating expectations regarding the continuation of the funding and a risk of discontinuity between one phase and the next.

In this first year of activity, the execution was very quick. The equipment still to be installed and the incomplete technical activities identified in December 2025 were regularized in the final report dated March 2026. By the same date, 1,464 maintenance interventions had been recorded, and for blocking failures, the 24-hour deadline had been met in 93% of cases. The time compression was effective for the supply component, but less appropriate for training and maintenance, which require a longer time horizon to consolidate local expertise and verify the sustainability of the results. The operational timeframes of the Work Plan were therefore substantially respected, but are not fully consistent with the duration and original rationale of the intervention.

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?

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

The intervention has strengthened one of the necessary conditions for reducing the use of foreign facilities, improving the technological equipment of diagnostic services, emergency rooms, and operating rooms. However, it is still premature to observe a measurable decrease in evacuations or medical migration. Available data on hospital activity volumes reflect their overall performance and do not allow us to isolate the specific effects of the program. Furthermore, there is no information strategy for new services and a referral system that allows local facilities to direct patients to rehabilitated hospitals.

The availability of technology is only one factor determining the choice to seek treatment abroad. Infrastructure shortcomings persist, along with limited availability of drugs and specialized personnel, weak transfusion systems, and insufficient protocols for healthcare safety and infection control. Public trust, financial coverage for services, and awareness of available services also impact healthcare migration. The program has thus created the potential to reduce the use of services abroad, but this

effect requires complementary interventions on clinical quality, skills, referrals, communication, and affordability.

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

No significant spillover effects towards non-direct beneficiary structures have been detected so far. Supply, maintenance, and training activities remain concentrated in the nine selected facilities, and no systematic mechanisms have been established to disseminate expertise or extend services to the rest of the healthcare network. Local providers also tend to favor expanding the intervention to other departments within the same hospital rather than supporting external facilities.

However, there are potential systemic implications that have not yet been fully explored. Disseminating information on new services could better guide patients and relieve other facilities; integrating technical laboratories and training with the Equipment Directorate could extend maintenance expertise to the national network; finally, the program could help make equipment purchased from other donors, but still unused because it hasn't been installed or maintained, operational. Such opportunities, however, would require a clear coordination strategy with the Ministry of Health and non-beneficiary facilities.

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?

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

The selection of target facilities favored the main urban centers and high-level hospitals, reflecting the territorial concentration of resources and excluding numerous rural and peripheral areas. Six facilities are located in Brazzaville and Pointe-Noire, where 62.7% of the country's healthcare workers and 77.7% of its doctors are concentrated, while only three are located in other departments. The distribution of the nine facilities therefore did not ensure equitable access for the populations of the interior regions.

The pilot nature of the intervention partly justifies the concentration of resources, but no measures have been planned to connect populations in inland areas to the strengthened hospitals. Peripheral health centers have remained outside the program's scope, and no referral, transportation, information, or community maintenance systems capable of expanding the intervention's reach have been activated. The program is therefore complementary to the revitalization of health districts promoted by the WHO, but has not yet contributed to expanding its coverage or reducing regional disparities in access.

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

The program has produced visible improvements in obstetrics, neonatology, and pediatric services where these were prioritized. In Makélékélé, a previously absent neonatology unit was activated; Blanche Gomes received equipment for neonatology, pediatrics, and emergency gynecology; in Talangaï and Loandjili, intensive care units and emergency management capacity were strengthened. Staff testimonials indicate improvements in the functionality of services and newborn care, but this is primarily qualitative evidence.

It is not yet possible to attribute a measurable reduction in maternal or neonatal mortality to the program. Available data show uneven trends across hospitals and are not comparable, as they use absolute values or percentages without common denominators and, for 2026, only cover the first trimester. Furthermore, constraints persist regarding ancillary infrastructure (oxygen, electricity), spare parts, consumables, and ongoing clinical training. The program has therefore increased the potential capacity of maternal and child services, but translating these new resources into improved health outcomes requires functioning infrastructure, care protocols, clinical expertise, and more robust monitoring systems.

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?

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

The Congolese government has not included in its 2026 budget a line financed from its own resources specifically earmarked for the maintenance of the Italian program's equipment. The only national line allocated to the acquisition and maintenance of biomedical equipment amounts to 50 million FCFA, approximately €76,000, a marginal amount compared to the needs of a fleet of over 5,000 devices. There is no evidence of dedicated allocations for 2027.

Sustainability is further impacted by hospitals' structural underfunding: personnel expenses absorb between 51% and 84% of their budgets, leaving very little room for maintenance and investments. Furthermore, allocated resources are sometimes subject to delays and difficulties in ensuring effective availability. The limited involvement of the Equipment Directorate and other ministerial technical services has prevented the program from impacting ordinary financial planning procedures and generating additional national commitments for maintenance continuity.

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

During the period examined, the PSD model was financed entirely through Italian resources, without a dedicated and quantifiable Congolese counterpart. The first €30 million transferred to the operator corresponds exactly to the €20 million disbursed by Cassa Depositi e Prestiti and the €10 million transferred by AICS. The resources were transferred to dedicated accounts at the Congolese Treasury but were not supplemented by national funds or a co-financing mechanism attributable to the Sectoral Budget Support.

The lack of a specific contribution does not violate the Congolese regulatory framework for PSD, which does not necessarily require direct funding from the delegating authority. However, ordinary state support for the health sector cannot be considered a counterpart to the program, as it is neither dedicated nor accounted for. The financial model therefore functioned during implementation thanks to Italian funds, but did not define the mechanism through which the Congolese government would cover the costs of maintenance and technical services after the financing ended, leaving post-project financial sustainability unresolved.

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

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

Phase I produced positive and documented technical results, but within a limited scope of nine facilities and through a single consolidated operator. Replicability on a larger scale cannot therefore be considered automatic: expansion would increase the need for specialized personnel, spare parts, infrastructure, and maintenance resources, in a context where the national budget allocated for equipment remains insufficient. Furthermore, the current five-year contract is limited to the current facilities and does not allow for simple extension to other sites, necessitating contractual renegotiation.

Phase II should therefore adopt a progressive expansion, primarily consolidating existing services, expertise, and maintenance systems and gradually incorporating new facilities or activities. Scalability will depend on the ability to pre-assess the infrastructure conditions of new hospitals, secure additional national resources, strengthen the transfer of expertise, and integrate the PSD model with the Ministry of Health's technical structures. Phase I therefore offers a promising operational basis, but not yet a fully validated model for large-scale replication.

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 main risks to the continuation of the project concern financial and management sustainability, the insufficient reception capacity of some facilities, and weak institutional integration. The limited involvement of hospital and departmental staff in planning has, in some cases, resulted in supplies not fully aligned with local conditions. Constraints related to electricity, medical gases, consumables, and maintenance also persist, while SBS conditionalities have remained focused on spending and financial commitments rather than on technical, health, and capacity-building outcomes.

However, risks related to political and social instability or supply disruptions have not materialized to any significant extent. To reduce systemic risks, Phase II should integrate the three pillars of the intervention (supply, training, and maintenance) into a unified sustainability strategy, complementing technological investments with enabling infrastructure, availability of consumables, ongoing training, and public ownership of the systems. It would also be necessary to link disbursements to verifiable results and enhance coordination with the Ministry of Health, hospitals, and other partners active in the sector.

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

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

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 MCIPPP, the Ministry of Finance, the relevant hospital directors, and the 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

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

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

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

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

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

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

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

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

