

DRC-IHP Trip Report: Ousmane Faye

November 2013

Keywords: Integrated Health Project; maternal, newborn, and child health; water, sanitation, and hygiene; family planning/reproductive health; malaria, tuberculosis, and nutrition

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Integrated Health Project
in the Democratic Republic of Congo



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TRIP REPORT
Ousmane Faye

1. Scope of Work: To participate in the 3rd Global Forum on Human Resources for Health in Recife, Brazil

| | |
|---------------------------------------|--|
| Destination and Client(s)/ Partner(s) | Recife, Brazil, and MSH Home Office in Arlington and Cambridge Global Health Workforce Alliance |
| Traveler(s) Name, Role | Ousmane Faye |
| Date of travel on Trip | Nov. 6 – 22, 2013 |
| Purpose of trip | <ul style="list-style-type: none"> To participate in the 3rd Global Forum on HRH To learn from the sessions the HRH experiences from different countries and the future direction of HRH globally To contribute to enhancing MSH visibility at US Congress level To work on MSH DRC Internal Audit recommendations To work on IHP PY4 workplan and budget |
| Objectives/Activities/ Deliverables | <ul style="list-style-type: none"> To participate and enhance MSH presence in HRH globally To contribute to increasing the number of U.S. Congress members oriented about MSH work in DRC To provide managerial responses to MSH DRC Internal Audit recommendations To contribute to finalizing and the IHP PY4 workplan and budget |
| Background/Context, if appropriate. | <p>The five-year, USAID-funded Integrated Health Project (IHP), awarded on September 30, 2010, supports the National Health Development Program of the Democratic Republic of Congo (DRC). The project has two components: Component 1, “Services” and component 2, “Other Health Systems,” designed to create better conditions for, and increase the availability and use of, high-impact health services, products, and practices in four provinces of the DRC with 80 target health zones.</p> <p>Component 1 supports the first strategic focus of the DRC’s national health plan: health zone strengthening. Component 2 corresponds to the national health plan’s second strategic pillar, support for health zone strengthening in six priority areas: human resource development; pharmaceutical management; health finance; construction/rehabilitation of infrastructure; equipment and new</p> |

| | |
|--|---|
| | <p>technologies; and improved health system management. Activities under Component 1 strengthen health zones' capacity to deliver services by addressing both the supply and demand sides of services. Activities under Component 2 create an enabling environment for strong health zones, with particular emphasis on leadership and governance and the provision of resources tied to performance to eliminate health system bottlenecks stemming from unaligned or absent policies, particularly at the provincial level.</p> <p>Areas of focus are: family planning; maternal, newborn, and child health; nutrition, malaria, and tuberculosis; neglected tropical diseases; HIV/AIDS; and water, sanitation, and hygiene. The project works with current health service providers, such as international and faith-based organizations, uniting them under a strategy to fully implement the minimum and complementary service packages that are at the core of improved basic health conditions for the Congolese people. MSH implementing partners on the IHP are the International Rescue Committee (IRC) and Overseas Strategic Consulting, Ltd. (OSC).</p> |
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2. Major Trip Accomplishments: Should include the major programmatic goals realized, relevant metrics, and stories of impact from the trip.

RECIFE, BRAZIL

The 3rd Global Forum on HRH:

The goal of this Third Forum was to elicit new political commitments on Human Resources for Health (HRH) based on technical evidence, in order to accelerate progress towards universal health coverage (UHC) and the attainment of the health Millennium Development Goals (MDGs). It brought together approximately 1,500 health workforce champions from national ministries, HRH experts from global agencies and organizations, researchers, policy makers, professional associations, civil society and local communities. The theme for this 3rd HRH global forum was *Human resources for health – Foundation for universal health coverage and the post 2015 development agenda.*

The Forum offered to participants¹ a rich program² with opportunities to learn from a variety of experiences of countries, institutions and individual professionals. I attended all the high-level roundtables. Each of them was organized as the lead sessions of the day. I also attended several commitments sessions, special events and track sessions of interest including:

Day 2: i) Multisectoral partnerships, investment and policy dialogue towards strategic HRH decision-making ; ii) Professional autonomy and social expectations

Day 3: i) Measuring health workforce performance ; ii) Promoting and managing diversity of health workers for universal health care (UHC)

During this HRH Third Global Forum I had the opportunity to learn more about specific country

¹ http://www.who.int/workforcealliance/forum/2013/list_participants.pdf

² http://www.who.int/workforcealliance/forum/2013/3gf_programme/en/

experiences in addressing HRH challenges towards UHC through implementation of revised HRH policies. The most successful examples of countries that are making progress towards universal coverage include Brazil, South Africa and Ethiopia. Their common determinants include political will, vision and relevant health sector reform, and commitment to increasingly allocating resources in the health sector, particularly in favor of addressing the HRH needs.

At the end of the HRH Third Global Forum the countries and institutional representatives made 83 HRH commitments, of which 57 were from the 55 Member States and 26 from other 27 constituencies, entities and organizations. The HRH commitments can be accessed at: http://www.who.int/workforcealliance/forum/2013/hrh_commitments/en/index.html. The **Recife Political Declaration** and the support statements received from civil society and other Global Health Workforce Alliance (GHWA) partners and members are available at http://www.who.int/workforcealliance/forum/2013/3gf_outcomes/en/index.html.

ARLINGTON, VA, and CAMBRIDGE, MA

Visit to the Offices of 4 Members of U.S. Congress:

On November 15, 2013, Crystal Lander and I visited 3 offices of Congresswomen (i.e., **Lois Frankel, Elizabeth Esey, and Barbara Lee**) and the office of Congressman **Adam Smith** in order to share MSH work in general and in particular to tell the stories from IHP work in DRC. That included how IHP is making a difference in terms of lives saved in the context of the Global call for action of “A Promise Renewed” (APR) which brought together Ministers of Health from 49 countries in Washington in June 2012 to accelerate the reduction of maternal, child and neonatal mortality (Millennium Development Goals 4 and 5). DRC is among the 5 countries where half of the global child mortality occurs. DRC MOH leadership participated in the APR meeting in Washington. In collaboration with all stakeholders, the Government of DRC adopted in May 2013 a strategic road map to accelerating the reduction of maternal and child mortality. In contribution to the DRC APR goal, IHP used the LIST (Lives Saved Tool) to estimate that more than 33,000 lives were saved among the children under-five at the end of the fiscal year 2013. The IHP goal is to save more than 80,000 lives by the end date of IHP, September 2015.

In addition to the APR there were specific topics of interest that were discussed with the Congressional staff, as follows:

Office of Congresswoman Lois Frankel - Josh Cohen, Foreign Policy and Legislative Assistant, and Kelsey Moran, Legislative Assistant FP and Women’s Issues

- How insecurity in the East of DRC affects the project’s operations and deliverables: The project is well organized to protect its assets and staff. IHP works with other partners involved in humanitarian and relief interventions to ensure that critical security information is timely received and shared. However, the timeliness of technical reporting as required by USAID remains a challenge for the insecure health zones IHP supports.
- Harmful practices such as raping babies: I reported that I had not heard of such practices in IHP health zones, but that it is possible that it occurs since the social norms and culture may prevail. Sexual violence on adolescent and adult victims has in the past been managed by resignation and silence. It is part of gender issues IHP is addressing with the local authorities and communities including civil society organizations (CSOs) and in partnership with other partners such UN agencies.

- Telling one compelling story: During the most recent field visit (August 2013) I conducted in Kasai Oriental, I visited the General Referral Hospital (GRH) of Dikungu Health Zone, where IHP was supporting a fistula care campaign for which the surgery phase just ended. I was particularly touched by a 70 year old fistula victim who expressed deep satisfaction with being healed and for the end of more than 40 years of sufferance, humiliation and isolation from her community. This may help to understand the magnitude of the fistula victims that are still suffering in their communities. When I left the GRH more than twenty fistula victims who reached the GRH at the end of the campaign decided to stay until they get treated.

Office of Congressman Adam Smith – Mina Garcia, Sr. Policy Advisor

The country ownership examples discussed included the following:

- The GODRC has started effectively allocating more financial resources in the health sector, i.e., procuring pharmaceutical commodities such as vaccines and essential medicines, and implementing an ambitious program of improving the health facility infrastructure that comprises renovation and equipment based on the standards defined in the National Health Development Program.
- IHP rolled out the Leadership Development Program (LDP) at provincial, zonal and community levels and strengthened the leadership and governance capacity of the MOH local authorities and community leaders. As results they managed to mobilize local resources and invest them in strengthening the health system, including a substantial contribution to renovation of many health facilities, revitalizing health areas, and implementing LDP projects meant to addressing challenges identified in improving outcome indicators.

During the discussions we advocated that as decision makers in USG resource allocation the Congress members take into consideration the important work that MSH and other NGOs are carrying out in strengthening health systems and in achieving critical outcomes and impact, i.e., improving health and saving lives of the most vulnerable populations. We also advocated that the Congress members allocate some of their precious time to participate in the field visits MSH plans to organize in countries where USG-funded programs are implemented. I invited them to make a visit to DRC!

Managerial responses to MSH DRC Internal Audit recommendations:

I participated in various individual and group meetings held at Arlington and Cambridge offices to discuss the findings and recommendations. In general, the commonly agreed thoughts are to support and undertake any relevant measures that will protect MSH from consequences of violation of policies and procedures pertaining to financial and operations management of MSH projects in DRC. IHP is the most at-risk project because of its overall funding level and funds spent in the procurement of many goods and services needed to ensure the attainment of the project results. The Internal Audit proposal of the DRC COMU structure modification includes hiring for a new key position of Director of Operations, which we agreed to consider in IHP PY4 workplan and budget as an expatriate in case it won't be possible to hire locally. Other key management actions that need to be implemented in order to further strengthen the MSH DRC control system comprise the following:

- To strengthen the compliance “unit” to serve as a “watch dog” to ensure that all the COMU operations are in compliance with MSH SOPs. That requires ensuring that the compliance unit is out of the control of the COMU and reports directly to MSH Country Representative. The compliance “unit” work will also include but not limited to the following:

- conducting unsolicited and unannounced field visits to assess and document the level of compliance of MSH field offices to MSH SOPs pertaining to operations: reviewing the procurement processes for goods and services including lodging and restaurant facilities used during field visits and training activities, and transportation and distribution services of pharmaceuticals commodities, medical equipment, IT equipment, gas for motorcycles, fuel and other cold chain supplies, and HMIS tools supplies for health zones;
 - conducting due diligence on any suspected violation of MSH code of ethics in managing operations at Kinshasa and field offices;
 - reporting to Internal Audit through MSH Country Representative on any potential fraud related activities;
 - At the onset of its establishment, the compliance “unit” will be trained and coached by Internal Audit in order to adequately perform its duties.
- To further mitigate the risks by increasing the control on operations at all levels. Therefore, by December 1, 2013, the signature authority delegation to the field offices will be revised to reduce the threshold for approving a purchase request from \$3,000 to \$300 and for issuing a purchase order from \$500 to \$100.
 - From now on the MSH Country Representative will include and lead in all monthly meetings a first priority talking point on the MSH code of ethics, procurement integrity, whistle blower policy, and how abiding by these MSH rules are critical in furthering MSHers professional growth and MSH’s goals.

I collaborated with Matthew Gameda of MSH Internal Audit (IA) to handle the communication to the USAID/OIG on the IA findings, including ensuring that the MSH DRC projects’ AOs and AORs were informed prior to having any official letters sent out.

The missing NorLevo® – With Matthew Gameda of Internal Audit, we discussed the NorLevo® reported missing on October 2013. As background, on October 4, 2013, MSH DRC received a message from the USAID mission in Kinshasa to verify and confirm receipt of the NorLevo®. Upon receipt of the request from USAID, MSH DRC leadership learned that the drugs have ‘already been distributed’ to MSH DRC regional offices. Acting on this information, the MSH DRC leadership team formed an internal team to investigate the matter. On December 14, 2012, UPS delivered to MSH DRC Kinshasa warehouse, a package weighing 120 kilograms, containing NorLevo® 1.5mg emergency contraceptives.

We agreed that the evidence gathered so far by the investigation team shows clearly that Mr. Jeancy Mbuku, the Warehouse Manager, is accountable for the missing NorLevo®. Therefore the report on the case investigation can be completed and closed. Matthew will provide a template to be completed by the investigation team. Philippe and Ousmane will support with the translation in English.

The action to replace the missing NorLevo® had been discussed with the CFO (Vickie Barrow-Klein), who confirmed that she was aware of the request and was waiting for the proposed purchase request (PR) for her review and approval. I worked with Corporate Procurement to complete the PR and submitted it to Vickie, who approved it on December 4, 2013.

Brownbag:

On November 18, 2014, Philippe Tshiteta and I delivered the attached PowerPoint presentation on MSH DRC and IHP contribution to “A Promise Renewed” (APR), a strategic road map to accelerating the reduction of maternal and child mortality that the Government of DRC adopted in May 2013.

IHP quarterly report:

I discussed with the IHP backstop team members the challenges that are still to be addressed to improve the quarterly reports. The FY3Q4 was painful to complete due to discrepancies and inconsistencies between the PMP and several data analyzed to produce the major content of the quarterly report, as if the drafts provided by the technical advisors have had no input from the M&E staff prior to completing the first draft report for the English translation. In addition, the reporting calendar and related deadlines are still not respected for several different reasons. We agreed to redesign the quarterly reporting calendar to include all critical steps and clearly specify accountability of persons involved for each of them.

PY4 workplan:

At this time, the IHP team had been unable to quickly finalize and submit the PY4 workplan, primarily due to the funding constraints that led to difficult communication with IRC. I worked with the IHP backstop team to address the most critical issue with IRC, which required having them accept to reduce their proposed budget to \$8 million or less. The discussion with IRC took much more time than anticipated. I was obliged to request USAID that the PY4 workplan submission due date be extended from November 30 to December 15, 2013.

I worked with Kristin Cooney to prepare comprehensive documentation of IHP funding constraints and all of the information that had been shared with IRC from March to November 2013. The documentation was completed as reference for a meeting between MSH and IRC Leadership meant to clarify misunderstanding in the partnership and correct IRC misconception and accusations.

Procurement:

I discussed with Matthew Bader to clarify the pending questions and make needed decisions that helped lift the hold on selection of vendors for the medical kits.

I discussed with Ned Heltzer the IHP procurement plan for pharmaceuticals commodities for PY4 and PY5. He advised that we consider the option to work on one order for two years. The priority commodities are known and shouldn't change by the end of September 2015. They include the lives saving commodities for children and mothers. The financial constraints that are anticipated in PY5 due to the higher level of funding in PY4 should be one of the key factors that influences the 2-year order option. I agreed with Ned that at some point prior to end of PY5 MSH should advocate to USAID to have them secure an order of priority pharmaceutical commodities to bridge the end of IHP and startup of the follow-on project to IHP. That is most critical based on the commodities availability challenges IHP faced in PY1 when transitioning from the AXxes project.

3. Key actions to continue and/or complete work from trip. Deliverables/Results:

- Debrief on the experience of MSH contribution and participation with MSH attendees at the HRH meeting
- Design a revised MSH framework and HRH Strategy
- Share the outcomes of the 3rd Global Forum on HRH with MSH DRC Country Leadership Team
- Organize follow-up discussions with the members of Congress
- Implement the managerial actions proposed in response to the Internal Audit recommendations
- Redesign the quarterly reporting matrix
- Submit to USAID the IHP PY4 workplan and budget

| Description of task | Responsible staff | Due date |
|--|---|--------------------------------|
| Debrief on the experience of MSH contribution and participation with MSH attendees | Anita Pirani, Zina Jarrah Bertra, Mary O’Neill, Jon Jay | Completed on November 21, 2013 |
| Design a revised MSH Framework and Strategy HRH | Mary O’Neill | Completed on February 10, 2014 |
| Share the outcomes of the 3 rd Global Forum on HRH with MSH DRC Country Leadership Team | Ousmane Faye | Completed on December 19, 2013 |
| Organize follow up discussions with the Members of Congress | Crystal Lander | Ongoing |
| Implement the managerial actions proposed in response to the Internal Audit recommendations | Ousmane Faye & Philippe Tshiteta | Completed on January 20, 2014 |
| Redesign the quarterly reporting matrix | Elena Chopyak & Ousmane Faye | Completed January 10, 2014 |

4. Contacts: List key individuals contacted during your trip, including the contacts’ organization, all contact information, and brief notes on interactions with the person.

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MSH-DRC OVERVIEW

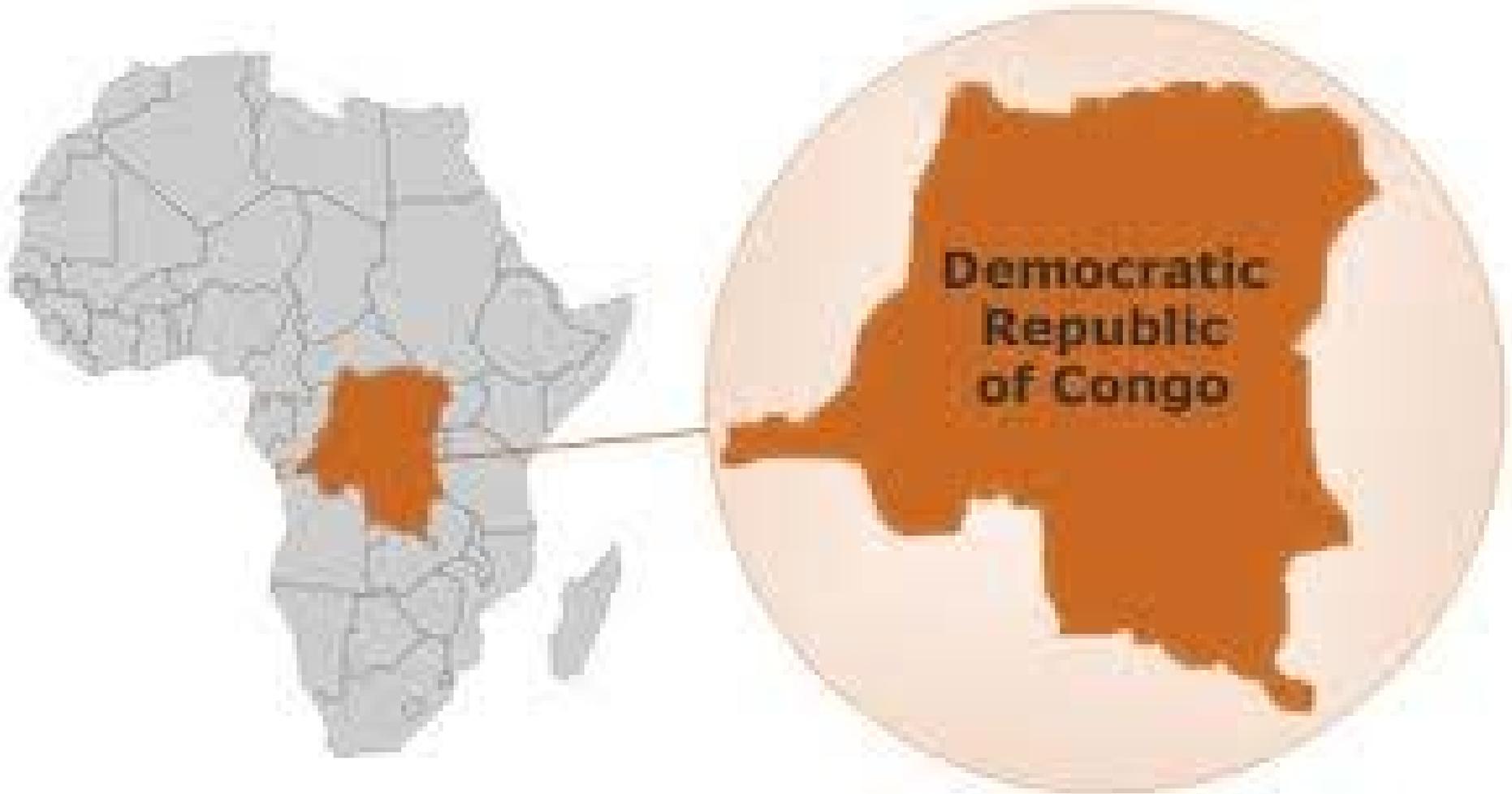
Dr. Philippe Tshiteta
MSH Country Representative
Cambridge, November 18, 2013

OUTLINE



1. DRC Background
2. DRC current status
3. MSH'S presence in DRC
4. What has MSH done so far in MCH
5. DRC main challenges

DRC Background (I)



DRC Background (2)

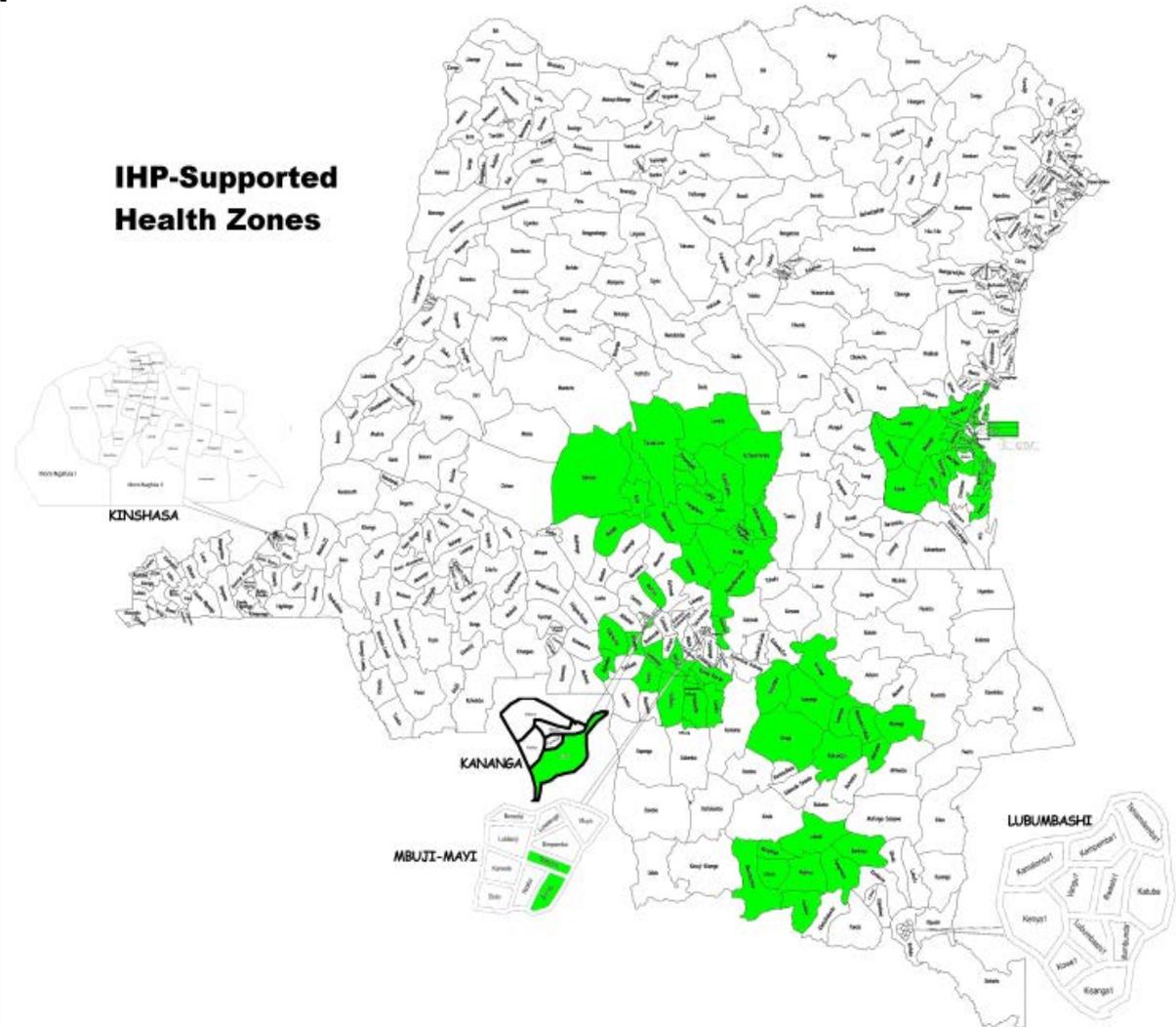


DRC Background (3)



DRC:

- 2.35 million sq. km
- Population: 86 M (70% in the rural area)
- 515 health zones (HZ)
- MSH in 80 HZ (16%)
- 1,509 health facilities covering 14.5 M people
- Some HZ are not accessible (no roads, insecurity)





DRC Background (4)

- Second largest in Africa after Algeria: 2,345,409 Sq. Km
- Shares 9,165 km of borders with 9 other countries
- Population: 86 million, fast growing
 - Most in extreme poverty,
 - 70% in rural areas, 30% in urban area
- Post-conflict state, very challenging environment
- Poor transport and communication network
- DRC is now putting in place policies and strategies that seek to reinforce the health system

Current MSH Projects



IHP

- October 2010
- September 2015

SIAPS

- September 2011
- September 2016

SCMS

- September 2012
- 2014

HPP

- October 2013
- November 2014

MSH's Presence in DRC



- MSH is well known, respected, and highly valued by MOH, USAID, UNICEF, WHO, other funders (e.g., Belgian and Canadian Cooperations)
- The Country Representative's role is well accepted by USAID and all, and actively welcomed
- MSH is the only implementing partner on the DRC health donors group coordination committee
- MSH is running the Vice Presidency of the Country Donors' Committee on Community-based MCH in DRC
- National FP & RH program has taken the leadership and coordinates all partners in FP and RH: process led by MSH

MSH's Presence in DRC: One MSH



- One MSH works in DRC: All three centers work together on IHP on a routine basis
- Projects always work to facilitate collaboration and to promote synergies
- Ongoing technical assistance provided by SIAPS to IHP on all aspects of pharmaceuticals management including APR
- COMU supports 5 MSH projects



Every hour :

- **Two (2)** women die
- **Thirteen (13)** newborn babies die
- **232** under-five children die

What has MSH done so far in MCH?



- Empowered by MSH, one of the DRC state/private medicine suppliers has been accepted as USG pharmaceutical wholesaler for the 1st time
- Two more suppliers are to join this year
- MSH provided technical and financial assistance to MoH:
 - National MCH norms exist now in DRC for the 1st time (jointly with WHO, UNFPA, UNICEF, and other partners)
 - DRC now has a specific and tailor-made work plan on APR
- MSH assisted the MOH to introduce into DRC NEM/List chlorexidrine 7.1% for umbilical cord care and misoprostol for prevention of postpartum hemorrhage

Main Challenges (I)



- Weak leadership at central level
- Under-equipped health facilities, in insufficient number, and inaccessible
- Maternal and child health is funded mainly by donors, operating in a poorly coordinated and non-sustainable fashion
- More than 14% of women still give birth at home
- Less than 4% of births are correctly managed

Main Challenges (2)



- Limited availability of essential medicines and other commodities
- Insufficient, unskilled and demotivated human resources
- Low service demand due to high health care costs

Projet de Santé Intégré en République Démocratique du Congo



USAID
DU PEUPLE AMERICAIN



DRC Child Survival Call to Action (CSC2A) A Promise Renewed (APR)

Cambridge, November 18, 2013



Background – (I)



Global call for action of “A Promise Renewed” which brought together Ministers of Health from 49 countries in Washington in June 2012 to accelerate the reduction of maternal, child and neonatal mortality (Millennium Development Goals 4 and 5)

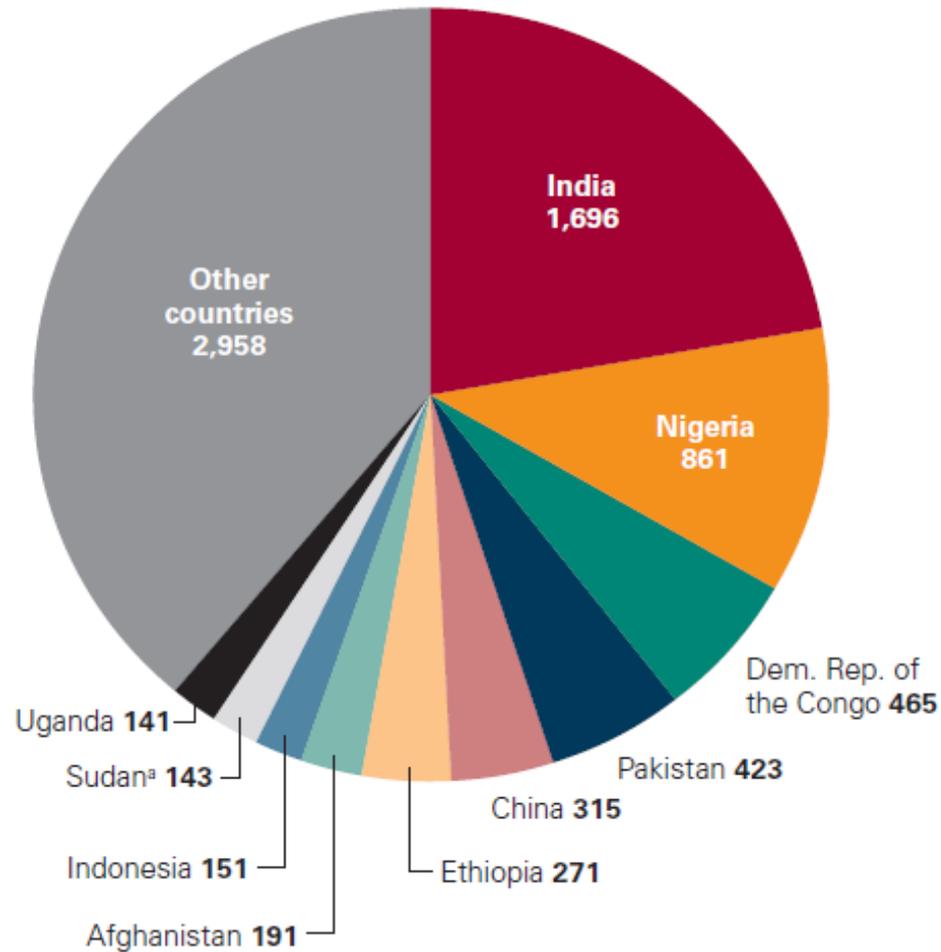
This call for action challenges the world to reduce child mortality in every country to a maximum of 20 deaths for 1,000 live births by 2035.

If this historic goal is achieved an additional 45 million lives would be saved before 2035, bringing the world closer to the ultimate goal of prevention of child mortality.

Background – (2)



Number of under-five deaths, by country, 2010 (thousands)



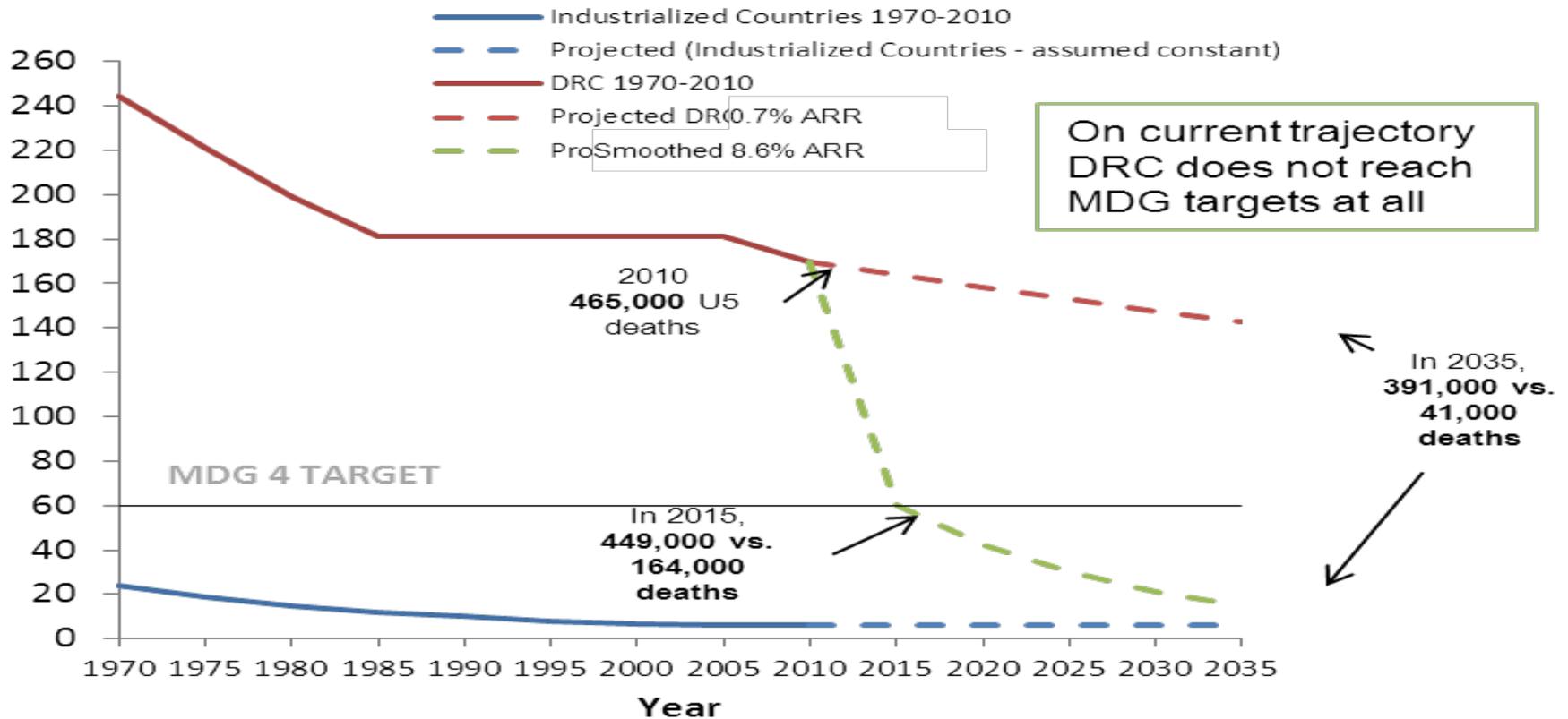
Background – (3)



U5MR

Deaths per thousand live birth

Under-Five Mortality Decline DRC 1970- 2035



DRC APR Program



Objective: to save the lives of 430,000 children under 5 years old and 7,900 mothers by 2015.

Six strategies including:

- i) Universal coverage of health care for under five children and pregnant women via “Family kits” including vouchers;
- ii) improvement of the continuity of care at the peripheral level including reference structures;
- iii) improvement of governance and management of health zones;
- iv) strengthening human resources (health care providers, staff motivation, quality of training);
- v) promotion of healthy behaviors ;
- vi) community mobilization.

Cost US\$ 1,1 billion.

APR launched in Kinshasa, 31 May 2013



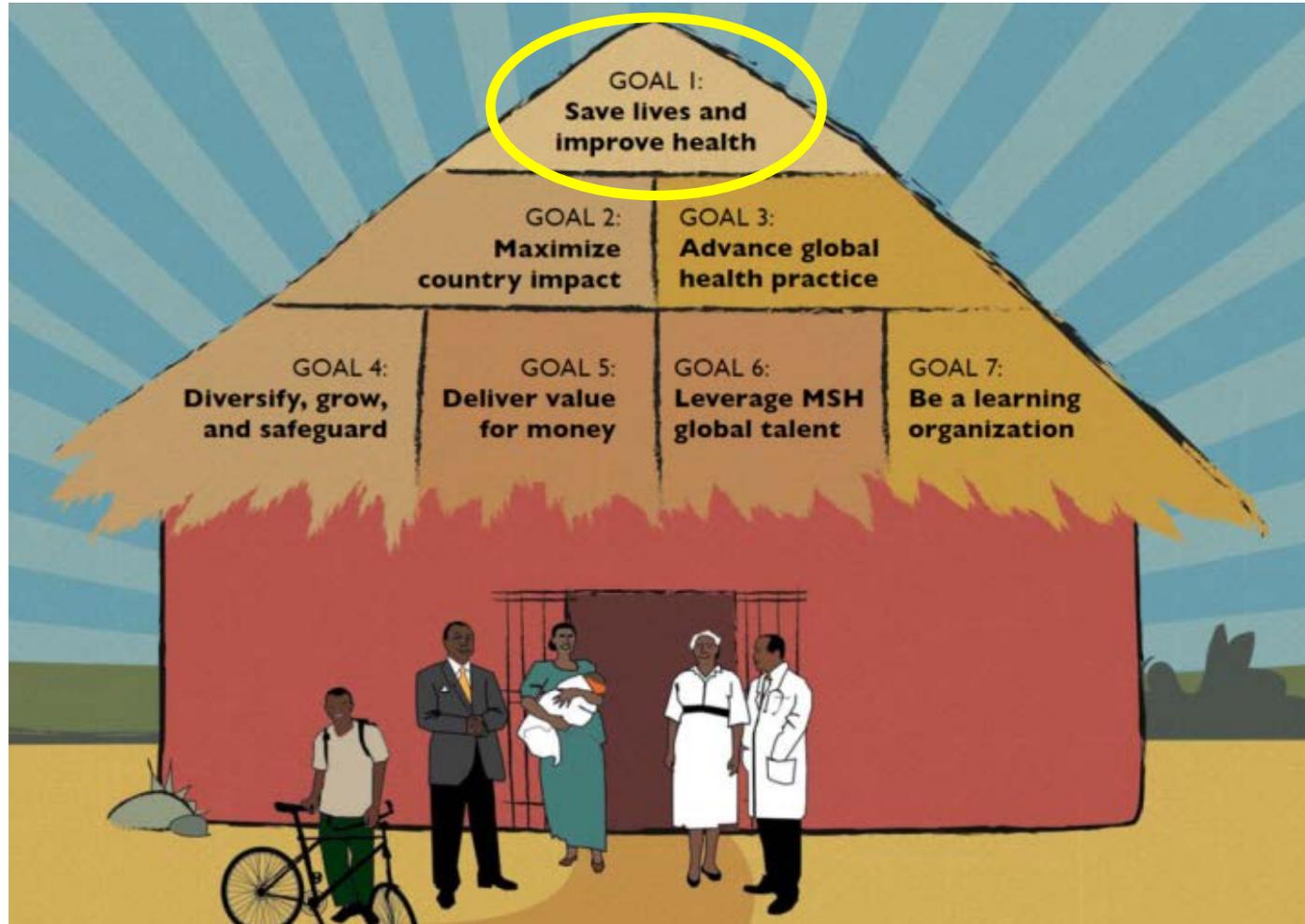
Goal 1 and the MSH Strategic Roadmap 2017

SIAPS

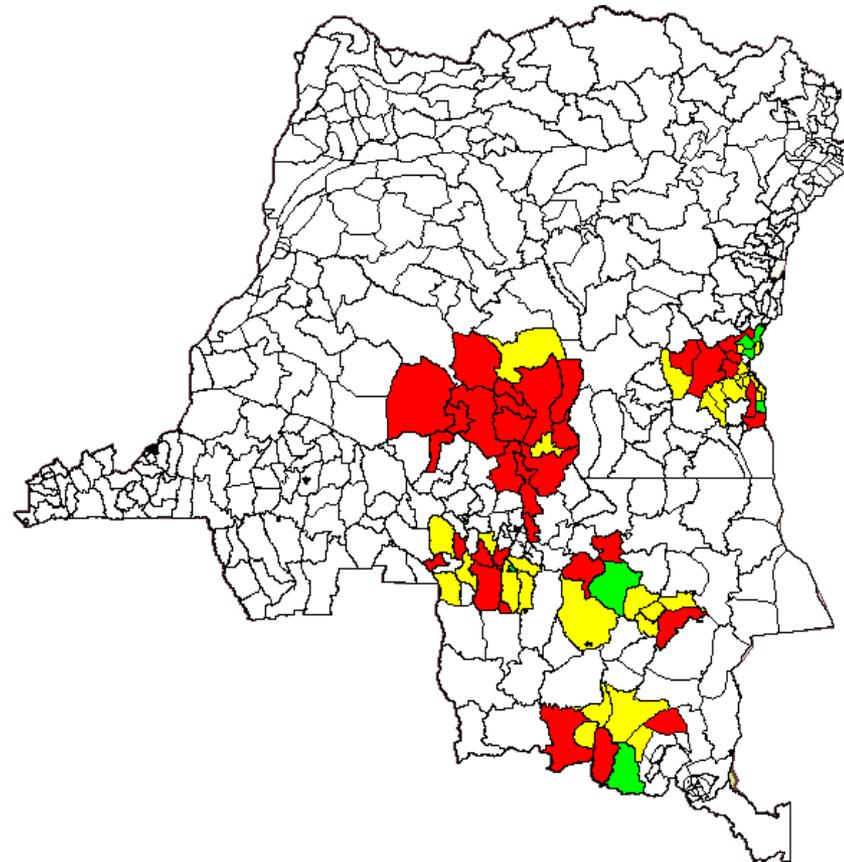
SCMS

HPP

IHP



IHP intervention Health Zones



- 37 priority or red HZs**
- 34 developing or yellow HZs**
- 9 demonstration or green HZs**

IHP Goal by September 2015



To save 80,000+ lives among young children

For children aged 1-59 months

| Health Intervention | Lives saved |
|----------------------|---------------|
| Preventive | 19,751 |
| Immunization | 9,358 |
| Curative after birth | 38,988 |
| Total: | 68,097 |

For children aged 0-1 months

| Health Intervention | Lives saved |
|----------------------|---------------|
| Preventive | 441 |
| Breastfeeding | 2,144 |
| Curative after birth | 9,895 |
| Total: | 12,480 |



IHP High impact interventions



Focused antenatal care

Labor & Delivery; Emergency obstetrical care

Essential newborn care

Newborn resuscitation

c-IMCI and i-CCM (diarrhea, malaria and pneumonia)

Immunization and preschool consultation

Essential actions in nutrition (e.g., Exclusive breastfeeding)

Family planning

Water sanitation and hygiene

IHP Achievement in PY3 – (I)



Estimated 33,000+ lives saved among young children

For children aged 1-59 months

| Health Intervention | Lives saved |
|----------------------|---------------|
| Preventive | 6,486 |
| Immunization | 3,002 |
| Curative after birth | 21,003 |
| Total: | 30,491 |

For children aged 0-1 months

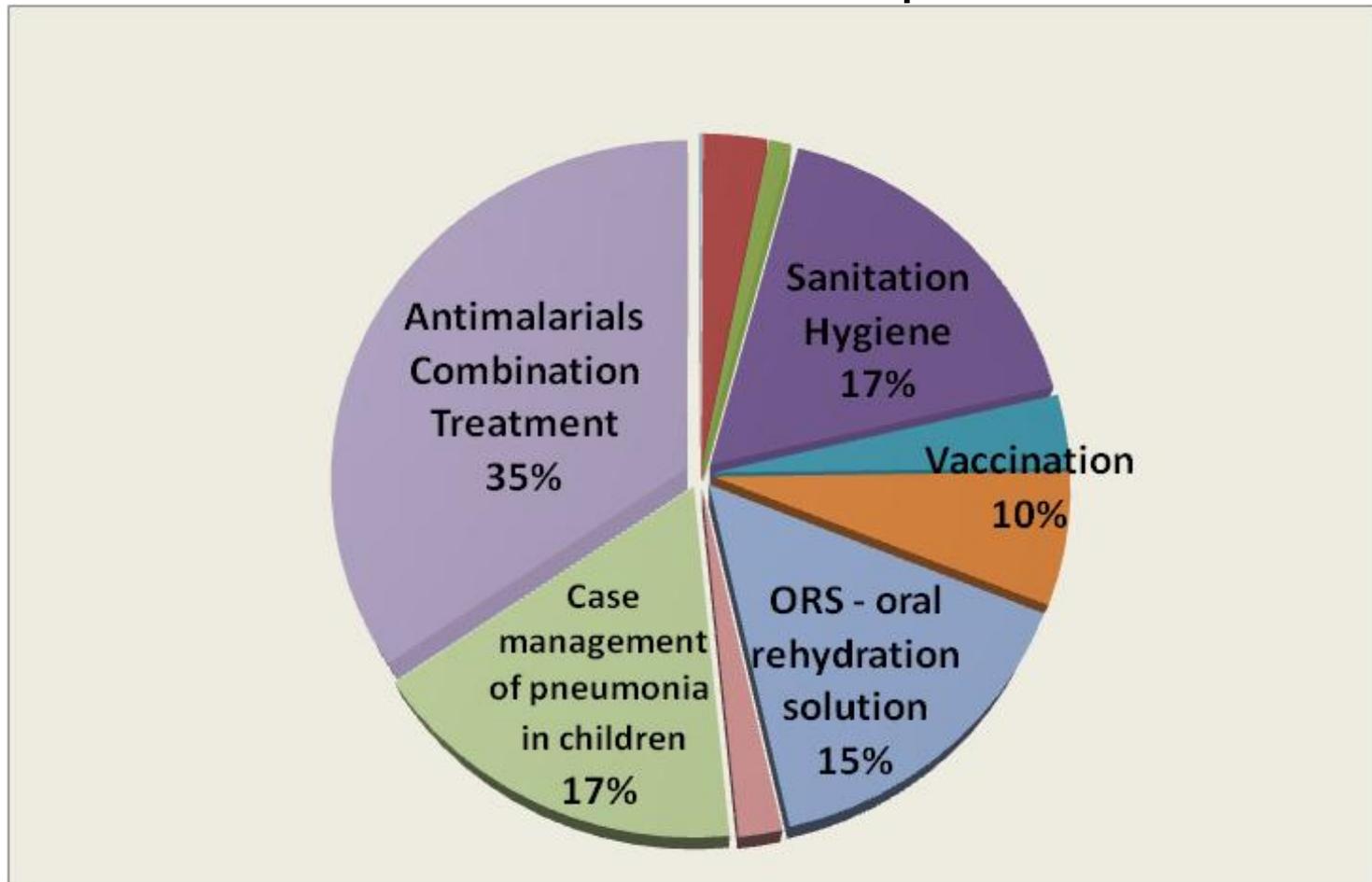
| Health Intervention | Lives saved |
|----------------------|--------------|
| Preventive | 445 |
| Curative after birth | 2,581 |
| Total: | 3,026 |



IHP Achievement in PY3 – (2)



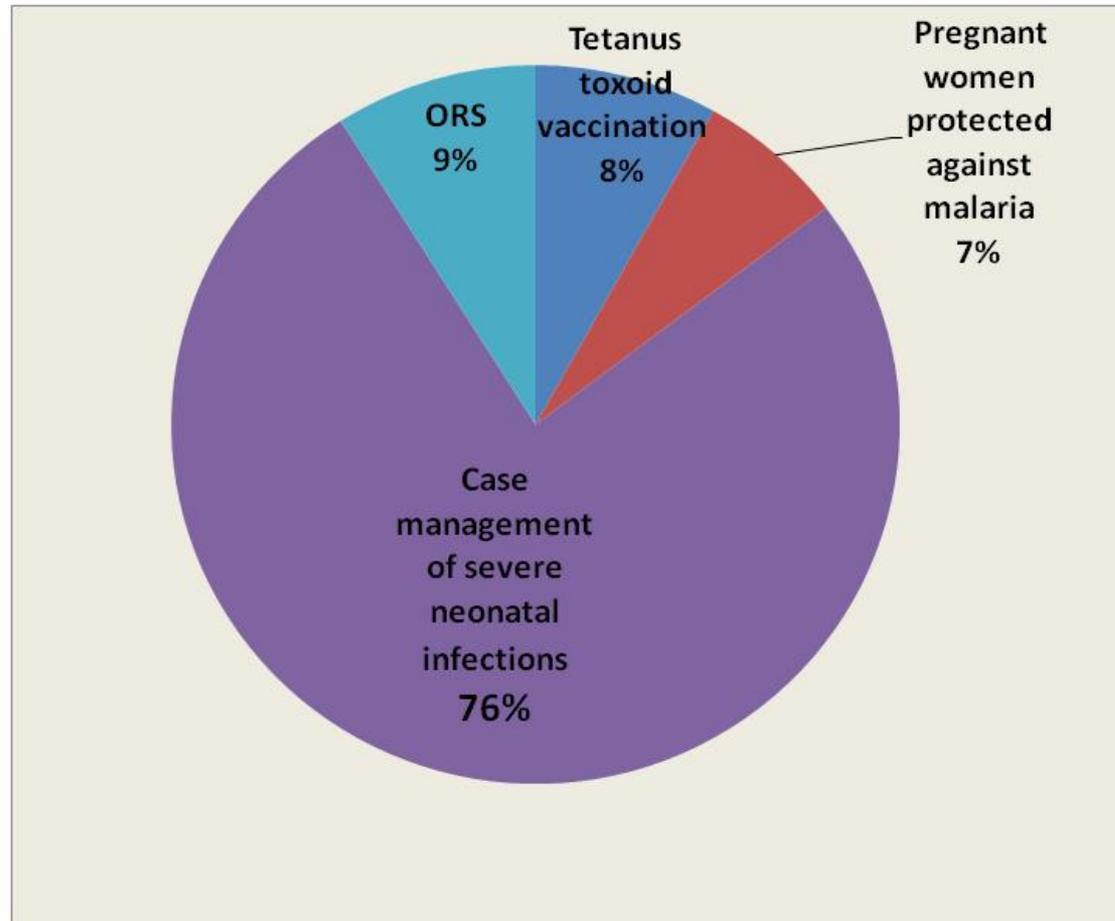
Number of lives saved for children aged 1-59 months by intervention relative to impact



IHP Achievement in PY3 – (3)



Number of lives saved for children aged 0-1 months by intervention relative to impact year



Addressing Challenges



- Keeping the acceleration pace in a context of delayed funding availability
- Mobilizing donors for additional financial resources
- Coordinating MOH programs and implementing partners' support to improve efficacy and efficiency
- Ensuring permanent availability of lives saved commodities
- Improving routine monitoring of implementation and production of reliable quality data for the accurate reporting on performance indicators and impact estimates

Projet de Santé Intégré

en République Démocratique du Congo



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