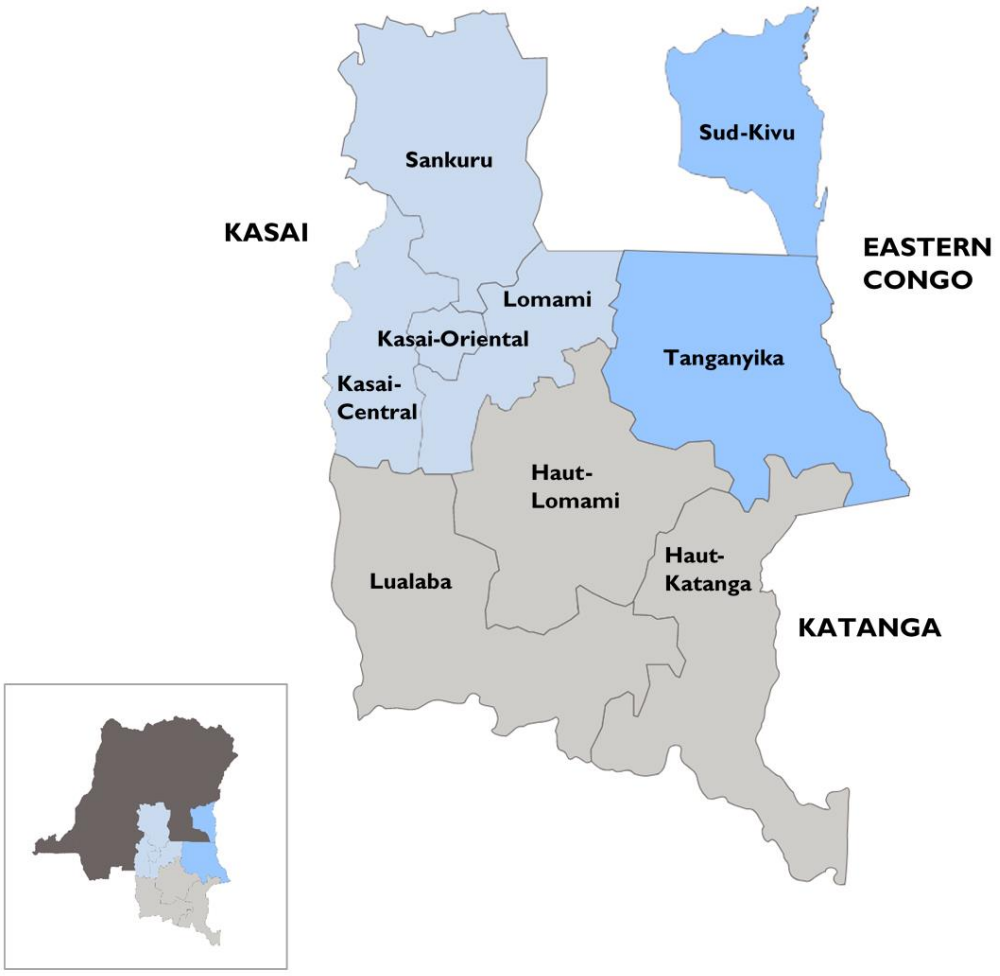


USAID'S INTEGRATED HEALTH PROGRAM

Year 1 Work Plan Narrative: November 2018-May 2019

August 31, 2018
Revisions: October 19, November 21, December 11, 2018
Approved December 14, 2018

Recommended Citation: Eerens, Peter and Pascal Ngoy, 2018. "USAID IHP Year 1 Work Plan Narrative." Prepared for USAID IHP by Abt Associates, Rockville, Maryland, original submitted August 31, 2018. Revisions submitted October 19. November 21, December 11, 2018. Approved December 14, 2018.

Submitted to: Richard Matendo, COR, Maternal & Child Health Program Specialist, Health Office, USAID/Democratic Republic of the Congo, (+243 81 555 4514), Kinshasa, DRC.

Cover Photo: Alexa Smith-Rommel, Abt Associates, via https://mapchart.net/.

Abt Associates Inc. | 6130 Executive Boulevard | Rockville, Maryland 20814 |

T. 301.347.5000 | www.abtassociates.com

With:

International Rescue Committee (IRC)
BlueSquare
Mobile Accord/Geopoll
Viamo
Pathfinder International
Training Resources Group (TRG)
i+Solutions
Matchboxology

USAID'S INTEGRATED HEALTH PROGRAM

Year 1 Work Plan Narrative

Contract No.: 72066018C00001

TABLE OF CONTENTS

ACRONYMS AND ABBREVIATIONS

ACT	Artemisinin-based Combination Therapy
AL	Artemether/lumefantrine
AMTSL	Active Management of the Third Stage of Labor (Gestion Active de la Troisieme Phase d'Accouchement – GATPA)
ANC	Ante-Natal Care
AOP	Annual Operations Plan (French: Plan d'Action Operationel)
AS/AQ	Artesunate/amodiaquine
ASSP	Accès Aux Soins de Santé Primaires
BCC	Behavior Change Communications
BCZS	Bureau Central de la Zone de Santé
BIP	Branding Implementation Plan
BLSQ	BlueSquare
CAC	Cellule d'Animation Communautaire (intermediary level between RECO (community health workers) and CODESA (health committee)
CBA	Capacity Building Advisor
CCC	Communication pour le Changement de Comportement
CAD	Club d'Amis Damien
CBD	Community-Based Distributor
CBO	Community-Based Organization
CCT	Comité de Coordination technique (Technical Coordination Committee)
CD	Communications Director
CDR	Centre de Distribution Régional
CDCS	Country Development Cooperation Strategy
CHW	Community Health Worker
CMAM	Community Management of Acute Malnutrition
CNAEHA	Comités Nationale d'Action de Eau, Hygiène et de l'Assainissement
CNP-SS	Comités Nationale de Pilotage – Secteur de la Santé (National Healthcare Sector Steering Committee)
CODESA	Comités de Développement de l'Aire de Santé
COGE	Comités de Gestion
COP	Chief-of-Party
COR	Contracting Officer's Representative
CORDAID	Catholic Organization for Relief and Development Aid

CPP-SS	Comité Provincial de Pilotage-Secteur Santé (Provincial Healthcare Sector Steering Committee)
CRMP	Climate Risk Management Plan
CS	Centre de Santé
CSDT	Centre de Santé Diagnostique et Traitement
CSO	Civil Society Organization
CTMP	Permanent National Multi-Sectoral Committee
DCOP	Deputy Chief-of-Party
DEP	Directorate d 'Etudes et Planification
DFID	Department for International Development (UK)
DGOGSS	Direction Générale d'Organisation et de Gestion des Services et Soins de Santé
DHIS2	District Health Information System 2
DHS	Demographic and Health Survey
DO	Development Objective
DP	Development Plan
DPS	Division Provincial de la Santé
DQI	Démarche Qualité Intégré (Approach Towards Quality Improvement)
DRC	Democratic Republic of the Congo
E2A	Evidence to Action (project)
ECDP	Early Childhood Development Program
ECZS	Equipes Cadre de la Zone de Santé
EEI	Equipes d'Encadrement Intégrée (English: Integrated Support Team)
EMMP	Environmental Mitigation and Monitoring Plan
EmONC	Emergency Obstetric and Newborn Care
EPI	Expanded Program on Immunization
EPP	Encadreurs Provinciaux Polyvalents
EU	European Union
FFP	Food for Peace
FOSA	Formations Sanitaires
FP	Family Planning
GATPA	Gestion Active de la Troisieme Phase d'Accouchement
GDRC	Government of Democratic Republic of the Congo
GFF	Global Financing Facility (World Bank)
GHSC-TA	Global Health Supply Chain-Technical Assistance (project)
GUC	Grants under Contract

HCD	Human-Centered Design
HCW	Health Care Worker
HF	Health Facility
HFC	Healthy Family Campaign
HFG	Health Finance & Governance Project
HRH	Human Resources for Health
HSSS	Health Systems Strengthening Strategy
ICB	Institutional Capacity Building
iCCM	Integrated Community Case Management
IFC	International Finance Corporation
IGA	Integrated Governance Activity
IGME	Inter-Agency Group for Child Mortality Estimation
IGS	Inspection Générale de la Santé (General Health Inspection)
IHP	Integrated Health Program
iHRIS	iHuman Resources Information System
IMCI	Integrated Management of Childhood Illness
IPS	Inspection Provinciale de la Santé (Provincial Health Inspections)
IPT	Intermittent Preventive Treatment
IR	Intermediate Result
IRC	International Rescue Committee
ITN	Insecticide-Treated Net
IVR	Interactive Voice Response
IYCF	Infant and Young Child Feeding
LB	Live Births
LLIN	Long-Lasting Insecticidal Net
LMIS	Logistics Management Information System
MAPEPI	Maladie à Potentiel Epidémique
MBX	Matchboxology
MDR/XDR	Multidrug-Resistant/Extensively Drug-Resistant
MDSR	Maternal Death Surveillance and Response
M&E	Monitoring and Evaluation
MEASURE	Monitoring and Evaluation to Assess and Use Results Project
MEDir	M&E Director
M Eng	Maintenance Engineer

MIP	Médecin Inspecteur Provincial
MIYCF	Maternal, Infant, and Young Child Feeding
MMR	Maternal Mortality Ratio
MNCH	Maternal, Newborn, and Child Health
MOH	Ministry of Health
MOP	Malaria Operation Plan
MPA	Minimum Package of Activities (French: PMA)
MSH	Management Sciences for Health
MTMSG	Mother-to-Mother Support Group
NGO	Nongovernmental Organization
NHSP	National Health Strategy and Program (French: PNDS)
NPCT	National Program to Combat Tuberculosis
OAC	Organization à Assise Communautaire
OCHA	Office for the Coordination of Humanitarian Affairs
PAO	Plan d'Action Operationel (English: Annual Operations Plan)
PCIME	Prise en Charge Intégrée des Maladies de l'Enfant
PEP (kit)	Post-Exposure Prophylaxis
PMI	President's Malaria Initiative
PICAL	Participatory Institutional Capacity Assessment Learning tool
PMP	Program Management Plan
PMTCT	Prevention of Mother-to-Child Transmission
PNAM	Programme Nationale d'Approvisionnement en Medicaments
PNCPS	Program National de Communication pour la Promotion de la Santé (National Communication Program for Health Promotion)
PNDS	Programme National de Développement Sanitaire (English: NHSP)
PNSR	Programme Nationale de la Santé de la Reproduction
PNLP	Programme Nationale de Lutte Contre le Paludisme
PNLT	Programme Nationale de la Lutte Contre La Tuberculose
PPP	Public-Private Partnership
PROSANI	Projet de Santé Intégré (project)
Prov Dir	Province Director
PSN	Plan Stratégique National
RBF	Results-Based Financing
RDC	République Démocratique du Congo
RDT	Rapid Diagnostic Test

REC	Reach Every Child
RH	Reproductive Health
RM&E	Research, Monitoring, and Evaluation
RT	Rapid Test
SBC	Social and Behavior Change
SBCC	Social and Behavior Change Communications
SC	Supply Chain
SC Adv	Supply Chain Advisor
S Eng	Sanitation Engineer
SGBV	Sexual and Gender-Based Violence
SMS	Short-Messaging Service
SNAME	Système National d'Approvisionnement en Médicaments Essentiels (National System for the Supply of Essential Drugs)
SNHR	Service National d'Hydraulique Rurale
SOW	Scope of Work
SP	Sulfadoxine/pyrimethamine
SSP	Soins de Santé Primaire
SVC	Strengthening Value Chains (project)
TB	Tuberculosis
TO	Transition Objective
TRG	Technical Resources Group
TWG	Technical Working Group
USAID	United States Agency for International Development
USAID IHP	USAID's Integrated Health Program
VDPV	Vaccine-Derived Poliovirus
WASH	Water, Sanitation, and Hygiene
WHO	World Health Organization
ZS	Zones de Santé (English: Health Zone – HZ)

1. WORKPLAN BACKGROUND AND CONTEXT

The mission of the United States Agency for International Development (USAID)'s Integrated Health Program (USAID IHP) is to work with the Government of the Democratic Republic of Congo (GDRC) and other stakeholders to strengthen the capacity of Congolese institutions and communities to deliver sustainable quality, integrated health services that improve the health status of Congolese men and women. The GDRC is committed to its Programme National de Développement Sanitaire (PNDS)[1] 2016-2020 and the revision[2] in process, which emphasizes the need to "increase coverage and utilization by the population of quality health services while ensuring equity and financial protection." Notwithstanding current efforts, many challenges remain in the Democratic Republic of the Congo (DRC)'s health systems—notably variable, often low-quality care and limited access to a package of essential services within overall limited domestic funding of the health sector.

1.1 DRC OVERVIEW

The DRC, the largest country in francophone Africa, has vast natural resources and spans a surface area of 2.3 million square kilometers. Fewer than 40 percent of its nearly 77 million inhabitants live in urban areas. Despite its unparalleled wealth in natural resources and the potential to be one of Africa's richest nations, the DRC's growth rate has slowed significantly since 2015. It ranks among the poorest countries in the world—176 of 187 countries (World Bank 2017).

The country faces unique technical and operational challenges that affect the health sector's efficiency, equity, quality, and sustainability as well as adaptability to changing needs. In 2015, the GDRC spent approximately US$19.7 per capita on health funding most of which was allocated to personnel (World Bank 2013 and 2015). Between 2006 and 2010, GDRC health expenditures from domestic resources were around 4 percent of its budget, but the country's health budget execution varies widely year to year. International financing for the DRC's health sector has increased to approximately US$200 million annually. Disbursement rates lag significantly behind commitments because of the health system's limited implementation capacity, and protracted underfunding of the health sector undermines the improvement and sustainability of health care delivery in the country (World Bank 2013).

The GDRC has achieved consensus on a development strategy and technical standards for health, and has also committed to strengthening service delivery systems in the health sector and to boosting basic health outcomes. Underlying strategic and planning work is presented in two existing strategies. The 2006 Health System Strengthening Strategy, and the revised version in 2010 focus on the development of integrated primary health care services in zones de santé (ZS), the most decentralized level of the system, while the PNDS 2016-2020 provides a robust framework for future initiatives. The development plans are often ambitious and encounter multiple implementation challenges, including resource mobilization. A July 2018 mid-term review of the PNDS 2016-2020 led to important findings of progress in the health sector and persistent challenges. After the midterm review, a revised PNDS with a 2019-2022 horizon tightens the focus on feasible, achievable interventions of proven value in achieving health outcomes.

---

1 National Health Strategy Program (NHSP); Fr: PNDS

2 Known as the "PNDS recadré 2019-2022

The government's health system currently deepens the decentralization initiated in 2006. The health system has three hierarchical levels: the central level, the intermediate level of the provinces, and the operational level in the periphery. In 2015, the government's reorganization changed the number of provinces from 11 to 26 (including Kinshasa). The decentralization framework is designed to transfer competencies—in health, primary and secondary education, and agriculture—to those provinces. In return, provinces are officially entitled to 40 percent of fiscal revenues collected by national authorities. However, existing provinces have limited institutional capacity, while new provinces are at the early stages of their development and often have limited means to discharge their responsibilities. The "contrat unique," a comprehensive single funding basket framework, has been created to channel and coordinate all funding, including partner funding, to the provinces.

The DRC has achieved important gains in maternal, newborn, and child health (MNCH)—including family planning, nutrition, water, sanitation, and hygiene (WASH)—and in combatting malaria and tuberculosis (TB). Yet, as of 2018, the DRC ranked 10th and 11th highest in the world in maternal and infant mortality, respectively (IndexMundi 2018). In 2016, only 61 percent of children in the DRC had received basic vaccinations (Willemot 2016). The DRC is still among the 40 countries that have a Maternal Mortality Ratio (MMR) exceeding 300 maternal deaths for every 100,000 living births (World Health Organization (WHO) 2012). Among the factors that contribute to maternal deaths are health systems weaknesses, including limited funding, insufficient availability of reproductive health goods and services, and socio-cultural barriers. USAID IHP aims to support and reinforce decentralization and to strengthen the institutions in the Ministry of Health (MOH) and communities in charge of implementing and resourcing health care delivery systems, as envisioned in the plans and strategies mentioned above.

2. PROGRAM FRAMEWORK AND DESIGN

USAID's Integrated Health Program (USAID IHP) seeks to leverage the potential of decentralization and accelerate reductions in maternal, newborn, and child deaths. The program supports the MOH to tackle challenges identified in the National Health Development Plan (PNDS 2016-2020): poor quality of service delivery and insufficient infrastructure, equipment, human resources, commodities supply, health financing, health information use, and governance.

The multi-sectoral framework of USAID's Country Development Cooperation Strategy (CDCS) aligns with the highest level of planning, sector-level policies, and strategies of different branches of the GDRC. Within the framework of GDRC's development objectives, USAID's CDCS pursues its overall goal of supporting a "long-term transition to more effective and empowering development in the DRC" via three objectives, each of which plays a role in USAID IHP's objectives framework.

The institutional-strengthening Development Objective 1 (DO1) directly links to USAID IHP's overall goal, and to its first objective in particular. The integrated Development Objective 2 (DO2) provides the background within which work needs to be undertaken in Kasai and Katanga regions, and the third objective, Transition Objective 3 (TO3) informs the nature of the work to be undertaken in Eastern Congo region. All objectives have elements within the nine provinces that USAID IHP is targeting.

In line with the commitment of different MOH partners and stakeholders, USAID IHP interventions correspond to the DRC's PNDS 2016-2020, which draws its own overarching strategic vision from the country's Health Systems Strengthening Strategy (HSSS). The PNDS is built on three axes, which divide into a limited set of sub-axes that offer a blueprint for aligning interventions at every level of the health system pyramid.

The first axis calls for the development of ZSs and continuity of care to improve availability of quality health services. The second axis calls for support of that development process, and the third outlines support to governance and the health sector's overall management. The recently revised and not yet adopted PNDS recadré 2019-2022 slightly redefines those axes: the first axis calls for development and

delivery of a well-defined, targeted essential health services package; the second calls for support to different systems needed to deliver this package; and the third maintains focus on improved capacity to manage, coordinate and ensure effective governance at different levels of the health system.

Within the above planning and implementation frameworks, the USAID IHP Results Framework will help the MOH and USAID determine USAID IHP's priorities for the coming years. USAID IHP will work closely with USAID and MOH counterparts to identify activities that support the objectives listed above. This work plan describes those activities, identifies their specific nature at the central, province, and ZS levels, and includes their geographical specificities based on detailed planning with each province. To achieve the greatest level of decentralization within our own technical assistance program, USAID IHP's regional offices are also decentralized entities that will ensure high levels of quality technical assistance at the provincial level. Each regional office, and ultimately each province, has a unique work plan.

An important anchor for the program to the central level of the MOH is the direct communication link with the Direction Générale d'Organisation et de Gestion des Services et Soins de Santé (DGOGSS). The DGOGSS serves as a portal to other contacts within the MOH.

2.1 THEORY OF CHANGE UNDERPINNING USAID IHP'S PROGRAMMING

The program's Theory of Change corresponds to USAID's Results Framework and is the logical foundation of USAID IHP's strategy to achieve USAID/DRC goals and objectives. It articulates problems, barriers, and existing environmental enablers, linking them to proposed program interventions and outputs, which in turn leads to desired outcomes and impact. The output indicators in the Theory of Change directly support USAID IHP objectives and are achieved through the interventions that we propose over the life of the program with Year 1 activities described in this document. The Theory of Change posits that USAID IHP's successful implementation of institutional strengthening and support to DRC health systems will result in more effective stewardship of financial, human, and programmatic resources in the health sector and significantly improved health outcomes for the population.

This theory of change is purposefully kept simple. It emphasizes harmonization between the overarching change theories of the MOH (the health systems strengthening strategy) and USAID IHP's logical framework (captured in the results framework). It also underscores that the program's complex health systems approach—which forms the scientific basis of our thinking about health systems—attaches great importance to consensus and convergence of stakeholders' views as an overall strategy towards simplification and reduction of the challenges to management of large-scale social systems, such as health systems.

3. PREPARATION OF THE WORK PLAN

The proposed activities in this draft work plan have been informed by the original proposal, and by a five-day planning workshop (July 23-27, 2018), during which staff from home offices and staff hired at that point studied the contract, the different program documents and MOH health sector documentation (policies, plans, strategies, guidelines, and evaluations).

In agreement with the USAID Mission, and due to the timing of start-up, representatives from the MOH did not participate. Thus, the workshop became a planning, orientation and team-building event for program partners only, with occasional participation by USAID officials. On day three, the program's USAID Contracting Officer's Representative (COR), Richard Matendo, introduced five USAID-funded projects with which the program needed to coordinate: Integrated Governance Activity (IGA), MEASURE Evaluation Project (Monitoring and Evaluation to Assess and Use Results (MEASURE) Evaluation), Food for Peace (FFP), Global Health Supply Chain-Technical Assistance (GHSC-TA) and Strengthening Value Chains (SVC). Also among workshop participants were representatives from the

Kinshasa School of Public Health, which the Program proposal presented as a future implementation partner.

Formal meetings with USAID Mission leadership took place during the workshop, while formal meetings happened later with the MOH (i.e. Minister of Health, Secretary General, and Director of DGOGSS). During the weeks after the workshop, USAID IHP continued to prepare for collaboration with the MOH. Team members incorporated outcomes of the workshop discussions in the draft work plan, continued conversations with other partners, and organized the handover with the Programme de Santé Intégré Plus (PROSANIplus), the predecessor project.

As part of the mobilization plan, USAID IHP planned transition activities with PROSANIplus. During the first meeting with that project's leadership, it was agreed to invite the MOH to lead a formal *Lessons Learned and Actions To Be Taken Workshop* (Atelier d'Apprentissage et de Transition PROSANI) to ensure USAID IHP would build on lessons learned. As the official visit to the MOH Secretary General's Office took place only two days before this workshop, this event was an additional opportunity to prepare in-depth planning discussions with MOH counterparts. This lessons-learned workshop, which took place on August 23, helped inform adjustments and clarifications to the current draft work plan and marked the formal start to future MOH-USAID IHP collaboration.

Following the submission of the work plan on August 31, 2018, the receipt of USAID feedback on September 18, 2018, and meetings between USAID IHP and USAID program management, Chief-of-Party (COP) Eerens and DCOP Ngoy prepared a schedule for revision of the work plan that provided for consultations with USAID and the MOH. The methodology included the following elements:

- Small team meetings between USAID IHP and USAID staff for each program component and cross-cutting aspects of the work plan. The objective of these meetings was for USAID IHP technical staff to present and test their understanding of the IRs and components, and discuss specific activities that USAID expects to see in this program.
- A meeting with the Ministry of Health DGOGSS during which USAID IHP presented the overall program and its three objectives, with examples of activities and the approaches we will take to achieve program results. This presentation—attended by a variety of MOH unit representatives and USAID staff—allowed for MOH questions and feedback on the program, and was a precursor to the following week's meetings.
- The following week, USAID IHP staff held meetings with technical and management units within the national level of the Ministry of Health to discuss in more detail the draft work plan, activities, and approach. These fruitful meetings established within the Ministry a much clearer understanding of the program's objectives and operational structure, and allowed USAID IHP staff to further elaborate their work plans in preparation for the meetings with the provinces.
- The final week of consultative meetings concluded with bringing in Division Provinciale de Santé (DPS) representatives from the nine provinces to meet with the USAID IHP staff to discuss the program, review the draft activities with the DPS, and incorporate any agreed upon comments and changes into the work plan.
- USAID IHP staff used the information resulting from this series of meetings to finalize the revised work plan for submission to USAID, due October 19, 2018. This work plan will also include a summary table of activities that have taken place from January 31, 2018-August 31, 2018, Annex A, which will be elaborated in the Annual Report (submitted October 30, 2018).

4. PARTNERS

USAID IHP leads a team of core sub-contract partners, including two intimately involved in the predecessor project implemented by Management Sciences for Health (MSH): International Rescue Committee (IRC) and Pathfinder International. Supporting partners include seven niche partners that combine international expertise in health programming with innovative solutions for fragile states: i+solutions, Matchboxology, Viamo, Mobile Accord/Geopoll, Training Resources Group (TRG), Bluesquare, and the Kinshasa School of Public Health. Key government project beneficiaries and partners are the MOH at all levels, community members, health committees, community health workers, and health providers.

USAID IHP's efforts require collaboration with various stakeholders, including the MOH, Catholic Organization for Relief and Development Aid (CORDAID), the World Bank, the United Nations Office for the Coordination of Humanitarian Affairs (OCHA) and other agencies and donors supporting health systems-strengthening. The program is also coordinating closely with numerous USAID projects to ensure complementarity and leverage of resources toward common goals, including: GHSC-TA, MEASURE Evaluation Phase IV, IGA, FFP, and the Strengthening Value Chains Activity.

5. OVERARCHING TECHNICAL APPROACH

USAID IHP was awarded to Abt Associates on January 31, 2018 but received a notice of suspension of work on February 15, 2018. This stop work order was lifted on May 26, 2018. There are thus several months of activities (minus the four months of the stop work order) that are not covered in this work plan, which covers September 1, 2018 through September 30, 2019. During the months preceding September 1, 2018, USAID IHP conducted start-up and technical activities and submitted numerous deliverables. **Annex A** presents highlights of activities during the period preceding this work plan.

For the initial 13-month period of this work plan, September 1, 2018 through September 30, 2019, USAID IHP will conduct analyses and establish related baseline data for each program objective; identify key beneficiaries and build strong relationships with them at national, DPS, and ZS levels; and begin implementation. Year 1 activities also reflect the need to navigate political calendars and processes, such as the pre-election process, which may delay ministries' work. Tasks under each of USAID IHP's three objectives are described below, and a table of all proposed activities, their timeframe, and outputs is in **Annex B,** which presents activities in chart format at the national, regional, and provincial levels. This chart also ties activities to USAID IHP objectives, and demonstrates alignment with PNDS objectives and strategies.

In addition to a main office in Kinshasa and three regional offices in Eastern Congo, Kasai, and Katanga, the current geographic scope for provincial and local activities will target in the following provinces, Haut Lomami, Lualaba, Haut Katanga, Tanganyika, Sud Kivu, Kasai Oriental, Lomami, Sankuru, and Kasai Central, while certain activities will take into account the importance of economic corridors. These provinces will be supported by offices in the following cities: Kamina, Kolwezi, Lubumbashi, Kalemie, Bukavu, Mbuji Mayi, Kabinda, Lodja, and Kananga.

Cluster Approach. To address the geographic scope, USAID IHP will consult with provinces to adopt (or if already in place, to expand or analyze to gain from their experience) the cluster model strategy to improve and provide essential services in their zones. The cluster approach organizes, encourages, and supports a higher-performing facility in each ZS based on population catchment, epidemiological data and consultations with the DPS. This model unit within a cluster acts as a champion for surrounding facilities to improve their performance and the quality of their service delivery.

5.1 USAID OBJECTIVES AND THE USAID IHP WORK PLAN

The following pages describe the USAID Results Framework whose structure guides the USAID IHP activities and work plan. Following the three objectives cited below is a short description of each IR and a high-level set of activities. Annex B elaborates details of the IR-related activities at the national, regional and provincial levels.

USAID IHP will pursue achievement of program goals through activities under USAID's three objectives.

- Objective 1: Strengthen health systems, governance, and leadership at provincial, zones de santé, and facility levels in target zones de santé.
- Objective 2: Increase access to quality, integrated health services in target zones de santé.
- Objective 3: Increase adoption of healthy behaviors, including use of health services, in target zones de santé.

5.2 OBJECTIVE 1

Strengthen health systems, governance, and leadership at provincial, zones de santé, and facility levels in target zones de santé.

The reframed PNDS 2019-2022 recognizes the need for a paradigm shift from a focus on means to a focus on results accompanied by select, feasible, high-impact priority actions consistent with available resources. An institutional capacity-building strategy must adapt to this new paradigm, and planning, implementation, and monitoring and evaluation should adapt accordingly.

The USAID IHP contract provides for the application of the Participatory Institutional Capacity Assessment and Learning (PICAL) tool at the DPS level and ZS levels. A PICAL cycle stretches over a two to three year period. Like other cyclical approaches (e.g. the planning cycle, the quality improvement cycle), the PICAL tool[3] may be used over several cycles.

The **Participatory Institutional Capacity Assessment and Learning (PICAL)** Index is an assessment tool to evaluate and monitor four themes of institutional capacity development: Demand for Institutional Performance, Organizational Learning Capacity, Administrative Capacity, and Institutional Strengthening Capacity. The PICAL tool is part of USAID/DRC's evolving assessment framework.

Two provinces (Lualaba and Upper Katanga) are already in the implementation phase. Sud Kivu and Kasai Oriental were also involved in such a process. Thanks to IGA interventions, several ZS and even facilities have applied the self-assessment. During the first year, each of the other provinces will also have a chance to carry out a self-assessment, and this will be followed by development of a capacity-building plan and implementation of a few actions.

The vision of PNDS 2019-2022 needs to be translated into operational action plans (Plan d'Action Operationel (Annual Operations Plan, AOP) (PAO) 2019). The contrat unique is the joint planning framework that partners should support. According to the needs of each of the provinces, USAID IHP will offer technical and/or financial support to this important planning exercise. Moreover, from the first year onwards, USAID IHP will respond to the call to help simplify this planning exercise. The reframed

[3] PICAL: (Angl.) Participatory Institutional Capacity Assessment and Learning

PNDS indicates the path to be followed: focus on feasible, high-impact interventions, and respectful of the obvious resources constraints.

This objective is based on the recognition that governance, leadership, and accountability are essential to fostering sustainable development. Weak governance and weak institutions hinder progress in DRC's health sector and result in multiple challenges.

Empowered Zones de Santé. A central tenet of USAID IHP's design is to work through existing MOH coordination mechanisms, focusing primarily on the operational (provincial and zones de santé) levels, while strengthening their coordination capacity. USAID IHP will provide programmatic, technical, and operational support to enable DPS and Equipes Cadre de la Zone de Santé (ECZSs) to be empowered stewards and effective managers of health system functions. USAID IHP will reinforce and help institute the norms and systems developed and promulgated by the national-level ministry as the structures and guidance to be used consistently throughout the provinces.

USAID IHP will use existing DRC self-assessment tools—such as PICAL—to help provinces and ZS assess institutional capacity levels and carry out performance improvement action plans. The program will build the capacity of DPS to cascade application of the PICAL tool to the ZS level and will help provinces identify capacity building needs and develop tailored solutions, employing human-centered design (HCD)[4] techniques to understand root causes of underperformance and barriers to change.

Based on information learned during the PICALs, the USAID IHP staff will design and facilitate targeted technical assistance, coaching, and leadership training to build DPS and ECZS skills in public financial management, reporting capacity, analysis and data use for improved disease surveillance and facility-level data reporting; management of Human Resources for Health (HRH); and stakeholder coordination and oversight functions. In line with DRC's decentralization process, provincial teams will participate in provincial and ZS coordination and planning meetings led by the MOH to jointly identify needs and priorities and coordinate plans. These "accompanied activities" make up a form of on-the-job training which, when conducted correctly, includes pre-activity coaching and post-activity de-briefing. We will use the accompanied activities model in many settings, including supporting the ZS Operational Action Plan development process, including providing input about gaps in service provision, preparing and conducting workshops and presentations.

Currently, results-based financing (RBF) is expanding as the mechanism to finance the country's efforts towards universal health coverage. Several provinces and their zones benefit from this output-based funding mechanism and from the "contrat unique" (or a single funding basket agreement) which ties management structures like DPS to this funding mechanism. Proof of this mechanism's importance is the government's recent inclusion of the Kinshasa Province among the provinces where RBF is implemented, with funding coming from domestic budgets.

USAID/DRC directly supports RBF through its contribution to the World Bank's Global Financing Facility (GFF). Where there is currently an existing RBF program (Lualaba and Haut Katanga) and where technical assistance is required, USAID IHP is designed to be a technical assistance instrument to optimize the DRC's RBF investments. In addition, USAID IHP will fund a limited number of RBF schemes in the program and support three zones in total: Kasai Central, Kasai Oriental, and Tanganyika. This approach will fully align with GDRC's model linking funding to achievement of agreed targets, perhaps

4 Human-centered design (HCD) is a systematic methodology to gather and use insights from end users insights that shape programs, systems and communications.

with the possibility of facility support of some kind (e.g. equipment, modest rehabilitation of office space) for exceeding targets.

At the same time, USAID IHP can employ technology to increase efficiencies and effectiveness. The program will work with the ministry and the provinces to use the performance dashboard tool, giving managers at DPS and ECZS level real-time, data-driven, decision-making capabilities. USAID IHP will coach users to operate the dashboards, understand their results, and to act on them. The dashboard will collocate data from multiple sources, including District Health Information System 2 (DHIS2); organization performance and quality of care assessments; RBF; PICAL; and patient exit surveys.

Other technologies are available to the MOH through the program. USAID IHP niche partner GeoPoll will provide MOH the ability to employ mobile phone-based surveys to monitor public perceptions of service delivery (understanding that mobile phone use has its limitations, especially in rural areas and among women).

USAID IHP will also support the ability of DPS and ECZS to implement the recently-developed MOH Community Dynamics strategy to strengthen community participation. The health sector has always played a leading role in mobilizing communities, and will continue to do so. But the Community Dynamics strategy is about community development in general and is thus the perfect vehicle for fostering inter-sectoral community collaboration. It will strengthen the capacity of Comités de Développement de l'Aire de Santé (CODESAs) and other civil society organizations (CSOs) to be true partners in addressing social and behavior change (SBC) and mobilizing the demand for and uptake of improved health services.

Under the leadership of the different DPS, USAID IHP's Equipes d'Encadrement Intégrés (EEIs (Integrated Support Teams)) will work with the ECZS and facilities to improve the functionality of existing community structures to fulfill their mandate as prime stakeholders of a stronger health system. Similarly, the program has the technological resources to help provinces conduct rapid assessments to evaluate CODESA functionality and tailor activities based on identified needs. In addition, depending on strategies that the provinces will develop in collaboration with USAID IHP's Provincial and Regional Offices, the program will mobilize resources to build the capacity of CODESAs and selected CSOs or community-based organizations (CBOs) through a Grants under Contract (GUC) program. In collaboration with DPS, USAID IHP will identify these community-level organizations and map their networks to strengthen stakeholder collaboration and their coordination capacity.

The provinces can further mobilize other technical resources: streamlining community scorecard approaches; launching a toll-free fraud and complaints hotline number for reporting corruption, abuse or similar allegations; and providing rights-based education to communities. In all efforts, USAID IHP will collaborate with DPS and ZS counterparts to improve community monitoring of health service performance, driving both local and provincial authority accountability and strengthening community oversight and stewardship of the health system.

USAID IHP's supply chain activities will mainly target the operational level of the ZS and will complement the supply chain investment currently implemented at the national and provincial levels under the Global Health Supply Chain-Technical Assistance (GHSC-TA) mechanism. This project's mission is to strengthen the in-country supply chain system by providing technical assistance to ensure long-term availability of medicines and other health commodities. GHSC-TA's supply and distribution reaches the provinces, the Centres de Distribution Régionaux (CDRs) and the ZS. From the ZS onwards, commodities need to reach health facilities, and it is USAID IHP's mandate to help provinces and ZS to do this effectively. GHSC-TA is also working on a Logistics Management Information System (LMIS) to reach the facilities, as currently it only reaches the ZS. This system should ultimately feed into the DHIS2-based LMIS. USAID IHP is aware of these challenging redundancies and duplications in the health system and will encourage partners to develop the necessary convergence of the two approaches.

In the meantime, USAID IHP will manage support to two systems to keep focus on the product for the customer or the patient. USAID IHP's activities aim to improve existing facilities for drug storage and management at the ZS level. The program will strengthen staff skills, procedures and information management across the value chain to support quantification, forecasting and timely inventory replenishment. Following investigation into pros and cons, we will consider the use of drones for delivery to remote and inaccessible areas.

5.2.1 OBJECTIVE 1 INTERMEDIATE RESULTS (IRS) IN BRIEF

IR1.1 Enhanced capacity to plan, implement and monitor services at provincial, health zone and facility levels.

The reframed PNDS recognizes the need for a paradigm shift in planning and execution of plans to achieve the desired results in the healthcare sector. There must be a shift from means logic to results logic, through identification of realistic, high-impact priority actions in line with available resources.

Any institutional capacity-building strategy must therefore contribute to radical adaptation of the methods of planning, implementation, and monitoring and evaluation according to this results-based logic. The institutions must identify realistic, high-impact priority actions.

USAID IHP provides for application of the HCD at the DPS level and ZS level. The different steps of this method are spread over a period of two or three years.

The launch of the reframed PNDS 2019-2022 in January 2019 requires institutions, at the intermediate and operational level, to establish their operational action plans (PAO 2019). The "contrat unique" is the model based on which each partner must envisage supporting planning and implementation of the planned actions for those provinces where the contrat unique is being implemented. According to the needs of each of the provinces, USAID IHP will offer technical and/or financial support to this important planning exercise. Moreover, from the first year USAID IHP will respond to the call for help in simplifying this planning exercise. The reframed PNDS indicates the path to be followed: concentration on feasible, high-impact actions within the constraints of limited resources.

For this first year, the main activities related to this intermediate result are as follows:

Activities:

- Introduce an institutional analysis assistance skill
- Carry out institutional analyses and support the development of capacity-building plans
- Support the DPS plan creation process and PAOs aligned with the reframed PNDS
- Build the capacity of the ECDPs and ECZS in primary healthcare management
- Prepare the introduction of the RBF program in the select ZS in Sud Kivu and Kasai Orientale

IR 1.2 Improved transparency and oversight in health service financing and administration at provincial, health zone, facility, and community levels.

Three actions will improve the transparency and accountability of the healthcare system: 1) capacity building within the DPS and the ZS; 2) greater involvement of the Cellules d'Animation Communautaire (CACs (Community Organization Groups)) and the CODESAs in the inspection, verification, and evaluation of services, and, thanks to reform at the central level, 3) operationalization of the role of general inspection and decentralized services of the DPS.

For this intermediate result, the PICAL index and the capacity-building plans will lead to guidelines that USAID IHP will help each of the provinces to follow in capacity building for administrative and financial management. USAID IHP will explore, along with the DPSs and existing partners (IGA**,** the European

Union (EU), Department for International Development (DFID)) how to provide technical and financial support for the training of ECDP/ECZS and healthcare facilities in financial management.

With respect to the role that the Inspection Générale de la Santé (IGS (General Health Inspection)) and Inspections Provinciales de la Santé (IPS, Provincial Health Inspections) must play, the reframed PNDS identifies four activities to be implemented during the next four years: 1) capacity building of IGS and IPS staff in the various areas of inspection control, 2) update of guidelines, inspection control tools and procedures, 3) support of inspection control coordination, and 4) structuring of inspection control feedback for establishment or update of policies, guidelines, and standards.

Since the IGS and IPS were just recently established within the MOH, USAID IHP proposes providing support on an ad hoc basis to six-month missions of the IGS in its role of coaching, regulation, and supervision of IPS in the provinces. We will take into consideration the results of this coaching to further support the IPS in their role of control at the provincial pyramid level. The program will also work in collaboration with the other programs of USAID, including that of the Integrated Governance Activity to support institutional capacity building.

We will carry out a feasibility study for the implementation of a direct line for reporting fraud and allegations for the IPS. Reporting will include, among others, gender-based violence, gender-based abuse, and/or unacceptable attitudes of service providers.

Activities:

- Provide coordination with the USAID IGA program for the analysis of targeted government institutions
- Train Core Teams of some DPSs in financial and administrative management
- Financially support some six-month missions of the IGS to Sankuru and Kasai Central
- Implement a system for reporting fraud, corruption, and abuse by telephone in the Kasai Central and Sankuru DPS

IR 1.3 Strengthened capacity of Community Service Organizations and community structures to provide health system oversight.

The PNDS 2019-2022 recalls that the effective participation of the population in healthcare actions is necessary for identification of the health problems and needs of the population and to strengthen community participation organizations through capacity building of members so that they can fulfill their role.

It is up to the service providers to establish an organized dialogue with the community to hear its needs and involve it in the healthcare action planning, implementation, and evaluation process. Furthermore, service providers are responsible for ensuring that the communities' point of view is taken into account in decision-making and in organization of healthcare service provision. Community control will contribute to improved quality of healthcare services offered and ensure the maintenance of skills acquired.

USAID IHP is therefore called to support increased community involvement by supporting the MOH in the dissemination and implementation of the community strategy plan in the 9 DPS. Several financial and technical partners have already implemented the community assessment map (DFID, IRC, Johns Hopkins University). For greater effectiveness, the program will use the community assessment map, which has proven its effectiveness in community conflict resolution by the members themselves with their own means, by favoring community dialog. All of these actions for the CODESA and civil society organizations will take into account the issue of gender for greater involvement of women in decision-making in the community.

Finally, Viamo will give special support to the MOH for the creation and development of community monitoring materials.

Activities:

- Evaluate the functionality of the CACs and CODESAs of five ZS per province and launch a CODESA and CAC training program
- Launch of the grant program to award community grants (in lump sums) to the CODESA in 10 ZS for organization of community transport in areas with difficult access
- Train the CODESA to use the community assessment map in five ZS per targeted DPS
- Develop the community monitoring tools
- Train members of community-based organizations and CODESAs on gender issues following the gender analysis

IR 1.4 Improved effectiveness of stakeholder coordination at the provincial and ZS levels.

The "contrat unique" is currently the reference for the consultation and coordination framework at the province level, even in the provinces where a formal introduction is not scheduled in the near future. Of the new provinces, only three are in the stage of signing the "agreement" between partners. However, it is not necessary to wait for this formal introduction of the contrat unique to comply with the agreement that the technical and financial partners, including USAID, have signed. It is even less necessary to wait for a similar approach to be created in the ZS.

USAID IHP has been assigned the mission of supporting the ZS in their efforts to better coordinate the identification and implementation of "realistic, very high-impact priority actions consistent with the resources available." This support can be financial, technical, or advocacy related. The PICAL index and the Capacity Building Plan will provide information to USAID IHP on the associated needs. This includes application of important guiding principles of the implementation of the PNDS.

The program will support the DPS and ZS managers to increase visibility of the mapping of activities at each level: "*Who does what and where?*"

The support strategy will consist in fully engaging as a model partner in this process of coordination between provinces and health zones and investing technical, financial, and other resources (through advocacy, informal coordination between partners) to build institutional capacity to successfully lead the planning, implementation, and monitoring of activities and services. From the first year, collaboration with the DPSs must result in the provinces' ability to strengthen or develop their own partner coordination strategy and to work together to write, disseminate, and publish it.

Activities:

- Fund organization of quarterly partner coordination meetings in nine DPSs
- Provide technical and financial support for organization of semi-annual meetings of the CPP-SS in the nine provinces
- Provide technical and financial support for organization quarterly review meetings of nine DPSs
- Participate in technical committee meetings of each targeted DPS
- Fund the organization of regular quarterly Comités de Gestion (COGE) meetings in 178 ZS
- Fund the organization of 12 regular CODESA meetings in 178 ZS
- Harmonize the process of implementation of the single agreement in the nine DPS

IR 1.5 Improved disease surveillance and strategic information gathering and use.

Based on an analysis of the different components of the national health information system, the reframed PNDS makes the following diagnosis: the DHIS2 is not yet capable of providing quality data in real time for decision-making and planning of healthcare activities. The problems related to this pillar are divided into three categories: 1) poor comprehensiveness, promptness, and accuracy of data collected, 2) poor analysis and use of health information, and 3) poor distribution of quality information. While this assessment is carried out for all 12 components, this diagnosis clearly applies to the "DHIS2 Soins de Santé Primaire (SSP)" component and the DHIS2, adopted as country software, to the "epidemiological surveillance" component, and the "program monitoring and evaluation" component.

The USAID IHP contract stipulates that the expected program results are 1) the increased capacity of the DPSs, ECZSs, and healthcare facilities to use the Maladie à Potentiel Epidémique (MAPEPI), 2) provide better epidemiological surveillance and health conditions, and 3) support an increase in DPS, ECZS, and healthcare facility staff capacity to collect and transmit data, and to analyze and use this data.

As many partners are active in this domain, good coordination of support is needed. As a technical and financial partner of the MOH, USAID IHP must ensure good coordination and synergy between the support provided per MEASURE Evaluation, so that all USAID assistance is consistent, complete, and does not overlap. An example is our support of the coordination of the DPSs and ZS, where coordination is simplified through better, informal communication between partners.

MEASURE Evaluation thus plays a role in capacity building for DHIS2 management at the central and provincial level. USAID IHP will follow closely MEASURE Evaluation's strategy of centers of excellence (in four ZS) to later distill the principles for dissemination and application on a larger scale. The same goes for the commitment already made by MEASURE Evaluation to provide tools for the operation of the DHIS2 for the period of the current plan. However, USAID IHP's support will supplement that of MEASURE Evaluation at the operational level with the 178 ZS. As this represents a significant investment of financial resources in recurring expenses, discipline, efficiency, and adherence to the results logic are highly important.

Considering the special context of the Ebola virus epidemic in one of our regions of activity (Eastern region), USAID IHP will also support the surveillance mechanism in collaboration with other partners.

Activities:

- Implementation of an excellent coordination and collaboration structure with MEASURE Evaluation advisors at the provincial level
- Add to the PICAL self-evaluation of institutional capacity an assessment of the information technology infrastructure of the DPS and unmet needs related to the epidemiological surveillance and health information function
- Provide support for capacity building in the collection, analysis, and use of data
- Support establishment of a sustainable response to Ebola in South Kivu
- Provide technical and financial support for regulatory meetings in collaboration with other partners
- Provide technical and financial support to the DPS team and IPS in organization of quarterly meetings for validation of data at the level of the DPS, IPS, and specialized programs (malaria, TB, Programme Nationale de la Santé de la Reproduction (PNSR))

IR 1.6 Improved management and motivation of human resources for health.

HRH is one of the weak points of the healthcare system in the DRC. USAID IHP will support all Early Childhood Development Program (ECDP) capacity-building actions to ensure proper human resource

management. The DPS will be supported in the use of human resource management tools such as the iHuman Resources Information System (iHRIS) and DHIS2 data for recruiting and assigning staff according to real needs and the available budget. A coaching program will be implemented according to MOH guidelines.

USAID IHP will also support all actions to motivate staff and thus improve retention—including positive incentives focused on recognition of staff distinguished in a particular area and/or negative incentives to discourage bad practices.

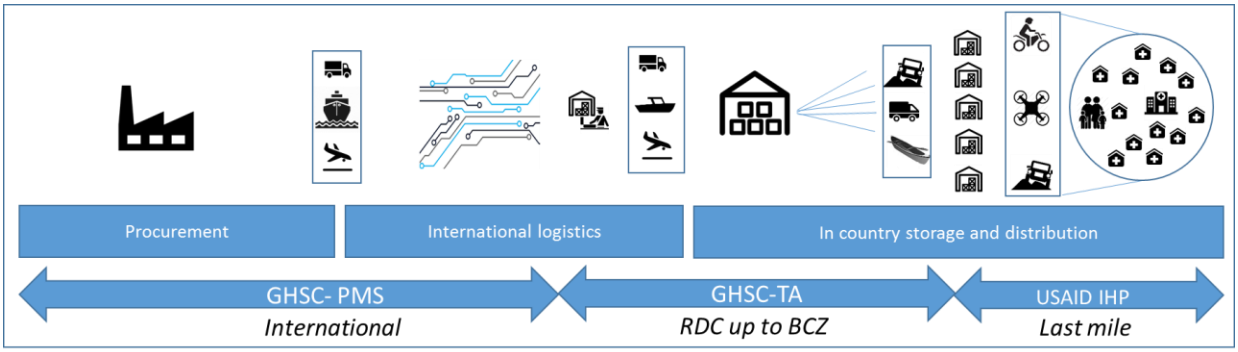
The program will also support actions to take gender into consideration in the recruitment and deployment of staff.

Activities:

- Train and equip the DPS in using iHRIS for human resources management
- Support the DPSs in the development of incentives to motivate the healthcare agents, depending on the local context (employee recognition program)
- Send DPS core teams to the regions of Kasai and Katanga to take into account the gender dimension of human resources planning and deployment
- Organize a workshop for creation of a training guide on the gender transformative approach

IR 1.7 Increased availability of essential commodities at provincial, ZS, facility, and community levels.

The contractual mission of USAID IHP covers one of the three components that make up the supply chain for drugs and essential products that USAID provides to Congolese institutions and communities: the last mile.



In line with the USAID/DRC Commodity and Supply Chain Roadmap and Results Framework, 2018–2022 and in support of the Système National d'Approvisionnement en Médicaments Essentiels (National System for the Supply of Essential Drugs (SNAME) Strategic plan 2017-2020, the purpose of USAID IHP interventions in supply chain management is to strengthen the leadership of the ZS that leads to:

- Improved data and inventory management and reporting at the health facility level
- Improved reporting, forecasting and quantification at the level of the ZS in support of sound provincial and national supply chain data management, quantification, procurement exercises and ultimately supplies
- More effective coordination of supply chain stakeholders
- More efficient and effective distribution

These improvements, combined with seamless cooperation at provincial level between USAID IHP, GHSC-TA, DPS and IPS, whereby USAID IHP works primarily with the Bureau Central de la Zone de Santé (BCZS) and Formations Sanitaires (FOSA) on last mile availability and GHSC-TA works with the Development Plan (DP) and CDRs on satisfying these last mile needs upstream, are expected to significantly contribute to continuous availability of drugs, essential medicines and commodities at health facilities and their communities.

In the immediate future, USAID IHP must ensure that its specific role in supporting routing of essential drugs from ZS to the healthcare facilities is significantly improved. This will require working with GHSC-TA in coordination with DPS, CDRs and ZS to align interventions—such as those for training and identifying product needs—so that each of these institutions is contributing to improved availability of commodities at the ZS level and the last mile, in line with the guiding principles of the PNDS.

In cooperation with GHSC-TA and coordinated with national institutions such as the Programme Nationale d'Approvisionnement en Medicaments (PNAM) and the vertical programs, provincially trained staff, assisted by i+solutions, will engage in training ZS staff. ZS staff will subsequently train relevant staff at health facilities. At provincial and ZS levels, the focus will be on quantification, forecasting and coordination. At health facility level, more focus will be put on the correct use of inventory management, reporting and requisition tools. Training of DPS and ZS personnel on supportive supervision in the field of supply chain management will also be part of the curriculum.

The activity plan also includes regular joint supportive supervision missions to ZS and health facilities by USAID IHP regional and provincial supply chain officers, and DPS and ZS pharmacists respectively. Periodic missions from the national level to the provinces and selective ZS have also been included.

The current system by which health facilities uplift medicine from the ZS pharmacies will be changed into an informed push delivery system from ZS to the health facilities, by using private sector transportation organized by ZS staff in cooperation with CODESA. Optimal route planning and consolidation of supplies for other health programs is expected to yield significant reductions in transportation costs, improved data exchange between health facilities and ZS, and improved optimization of stock levels at health facilities. In the first year, a pilot will be undertaken in three ZS in each region (nine in total).

Activities:

- Conduct rapid assessment of the supply chain in the ZS
- Support transport of essential medicines between ZS and health centers
- Make available stock and data management tools on the ZS and CS level
- Undertake SCM capacity building activities at the level of ZS and health facilities (HFs), in consultation and coordination with GHSC-TA and DPS
- Support ECZS in quantification and distribution of drugs at HF level
- Effectuate regular joint supportive supervision missions at all levels
- Pilot the informed push model at the last mile in the targeted ZS
- Support improvement of storage conditions at the ZS level
- Advocate to make sure that the needs at the last mile are taken into consideration in discussions and decisions related to e-LMIS at the national level

IR 1.8 Strengthened collaboration between central and decentralized levels through sharing of best practices and contributions to policy dialogue.

Within a context of decentralization, there is a tendency for local-level entities to develop in a vacuum. USAID IHP will support activities to share information at all levels to promote the integration of lessons learned at the operational level in the development of national policies and strategies. The program will support the relay of information from the local level to the provinces, and from the provinces to the central level. USAID IHP teams will actively participate in different cooperative efforts at all levels of the healthcare pyramid to share lessons learned and influence decision-making to improve the healthcare system, in particular, in the CNP-SS (Comité National de Pilotage-Secteur Santé (National Healthcare Sector Steering Committee), the CCT (Comité de Coordination Technique (Technical Coordination Committee)), the technical commissions of the CNP-SS, the CPP-SS (Comité Provincial de pilotage-Secteur Santé (Provincial Healthcare Sector Steering Committee)), the technical commissions at the provincial level, COGE meetings at the ZS level, and CODESA meetings. Outside the cooperation frameworks, the program will support the organization of workshops and regional and/or national conferences to share lessons learned and allow members of the community to share their experiences with the program.

Activities:

- Participate in meetings of CNP-SS technical commissions (funding and governance)
- Participate in CNP-SS meetings
- Under the auspices of USAID, share lessons learned with the different programs
- Organize a workshop at the national level to share lessons learned

5.3 OBJECTIVE 2

Increase access to quality, integrated health services in target ZS

Activities in support of this objective will address factors that impair availability, access to and demand of health services that can vary between provinces. These include incomplete service packages, deteriorating infrastructure, shortage of essential equipment and drugs at the facility and community levels, negative provider attitudes such as gender biases, long distances to facilities, and inconsistent referrals. Primary Health Care Workers (HCWs) have often received inadequate or incomplete education and training and have limited resources and tools at their disposal. Clients accessing services often find unmotivated, under-trained, and under-supervised providers.

Health zones use different strategies to continuously expand different types of coverage. For those that struggle to expand coverage, the program will propose the cluster model, i.e. identifying at least one high- or higher-performing health center that functions as a model to nearby health centers, performing outreach and eventually providing support to subsidiary facilities. This creates decentralized clusters. We then use well-performing facilities to serve as resources, models and "coaches" to others, continuing in this way into more remote areas until a majority of facilities are reached.

USAID IHP will make intensive use of the MOH guidance, the "Approach Towards Quality Improvement" (Démarche Qualité Intégré – DQI), which was also the subject of a presentation during the PROSANIplus transition workshop. This sophisticated MOH framework bundles the essence of eight existing quality-improvement packages into one single recommended approach. While still in the early stages of large-scale implementation, it has proven to positively alter processes, outputs and health outcomes. DQI calls for periodic, short, competency-based trainings, for refresher and on-the-job training with simulations using DQI checklists, and for immediate, corrective feedback.

Many opportunities for better integration exist: in some ZS, there is a need for integrating existing MNCH services with HIV and AIDS prevention services supported by other partners. One solution is ensuring that supported facilities without prevention of mother-to-child transmission (PMTCT) sites can refer pregnant women to the nearest facility for this service.

Elsewhere, the need for stronger interventions exists (e.g. improved delivery of essential nutrition actions) or for capacity to deliver key basic nutrition interventions at facilities (e.g. integrate quality nutrition counseling and services in all antenatal, delivery, and post-natal contacts, as well as during immunization and other child health visits).

Specific disease-based interventions must operate with high quality standards for each component of the intervention. In such cases, province teams (DPS and USAID IHP Provincial Offices) will need to support ZS to ensure a high level of compliance with programmatic standards. This support may include training, supervision, coaching, quality improvement techniques, and operations research. For instance, USAID IHP will help provinces and ZS strengthen TB case management following the current National Strategic Plan for TB, as well as the WHO's 2017 Updated Guidelines for Treatment of Drug-susceptible Tuberculosis and Patient Care. Through strengthening provincial and zonal capacities, we will ensure provision of TB screening, case detection, diagnosis and notification; support timely, appropriate TB treatment and ongoing case management with close patient monitoring to ensure they complete treatment; and reinforce linkages to community support to improve adherence and treatment success, as well as identifying lost-to-follow-up patients. USAID IHP will also collaborate with two DRC partners for TB programs: USAID's Challenge TB and the Global Fund.

Interventions will reduce barriers to demand and access to health services. In each of its three regions, USAID IHP will take into account the specific challenges and their impact on unmet needs: integrating service provision as explained above, e.g. offering infant and young child feeding (IYCF) or family planning (FP) advice during ante-natal care (ANC); supporting task-shifting, e.g. Community Health Worker (CHW)s' treatment of severe acute malnutrition; and shifting and extending health services to the community level via Integrated Community Case Management (iCCM) or Outreach (Stratégie Avancée (Advanced Strategy)). Enabling technologies include a toll-free fraud and complaints hotline and an mHealth tool for tracking referrals. Employing HCD techniques and gender analysis results, the program will design interventions to improve health providers' attitudes and interpersonal communication skills in facilities and communities.

To achieve service quality improvement, USAID IHP will work with DPS, ECZSs, and CBOs on rehabilitation projects; prioritize and phase facility renovations and develop maintenance plans led by provincial construction engineers; and develop an equipment procurement plan for which orders will be placed in Year 1.

Financial costs can further inhibit access. USAID IHP will help provinces explore health financing approaches to reduce financial barriers and help communities share the costs of health care and protect against catastrophic health expenditure. Options include introduction of micro-health insurance or negotiating Public-Private Partnerships (PPPs) for sponsorship in Katanga, such as voucher schemes for flat-rate payment from mining companies. These approaches will be applied differently in each sub-region according to factors such as population density and mobile phone network penetration.

5.3.1 OBJECTIVE 2 INTERMEDIATE RESULTS (IRS) IN BRIEF

IR 2.1 Increased availability of quality, integrated facility-based health services.

According to the Key Indicators Report of the Service Delivery Assessment 2017-2018, nearly 60% of health centers and 77% of reference health centers already offer the basic package of services as defined by the MOH. Overall, it is in public sector facilities that the rate is highest, at 66%. In the

nongovernmental organization (NGO) sector or the faith-based non-profit sector, these rates are only 52% and 54%, respectively. In the private, for-profit sector, only 41% of facilities offer the full package.

The provinces of Lualaba (87%), Sankuru (84%), and Haut-Lomami (82%) have a greater proportion of facilities that offer the basic package of services. In the Kasaï-Oriental (29%) and Tanganyika (26%) provinces, the offer for full package of basic services is significantly lower. Overall, and throughout the country, nearly all facilities offer outpatient curative care for children. Antenatal consultations (96%), treatment of STIs (95%), routine vaccinations (90%), and child growth monitoring (89%) are the most commonly offered services, whereas family planning services rank amongst the least offered (68%) services. There are inter-province disparities. New provinces resulting from the recent decentralization process have greater needs than the already existing province systems.

There are several tools for improving service quality and filling programmatic gaps: the primary healthcare department has developed treatment algorithms; clinical and therapeutic guides are available for healthcare workers at referral hospitals; and the DQI for evaluation of service quality is ready for large scale implementation. Specialized programs (e.g. PNSR, Programme Nationale de la Lutte Contre La Paludisme (PNLP), and Programme Nationale de la Lutte Contre La Tuberculose (PNLT)) have also established guides or treatment protocols.

Programs such as reproductive health (RH), MNCH, TB, Malaria, Nutrition, and WASH have detailed documentation of their technical and programmatic specifications. This allows for inclusion of a broad range of individual and detailed activities in the work plan in support of a customized yet comprehensive package of quality services to be offered by the facilities.

The needs for capacity building are significant and vary, while resources are limited. Therefore, from the outset, USAID IHP will conduct an assessment to identify the individualized support that healthcare facilities require in each province. Moreover, other financial and technical partners are actively supporting services in the same provinces. This requires harmonization and collaboration.

Activities:

- Carry out an assessment to identify the different actors and the support needs in the 9 provinces
- Increase the use of treatment algorithms, service flowcharts, technical guidelines, and therapeutic protocols at the HCs and referral hospitals to improve the quality of services offered
- Support integration and extension of Gestion Active de la Troisieme Phase d'Accouchement (GATPA), pre-eclampsia, neonatal resuscitation, etc.), monitoring of maternal deaths and response, family planning, nutrition, malaria, and tuberculosis in the centre de santé (CS) and referral hospitals
- Conduct the DQI in healthcare facilities to identify bottlenecks in service provision and propose appropriate responses
- Identify a first set of cluster candidates for maternal and neonatal health to serve as learning and capacity-building sites

IR 2.2 Increased availability of quality, integrated community-based health services.

With the soon to be announced Community Health Strategy, the MOH has taken up the challenge to reposition the community as a partner, actor, and beneficiary of all healthcare services. In the health sector, as in other development sectors, strengthening community systems is a relevant approach to promote capacity building of community organizations and community structures. This approach also offers a mechanism to expand service delivery where facilities fail to meet needs of the population. It ensures sustainability of health activities at the community level.

The 2013-2014 Demographic and Health Survey (DHS) indicates that in rural locations, the distance to reach health services is a major problem for 48% of women, compared to 25% in urban environments.

In such locations, the community can play a substantial role in ensuring complementary coverage when ZS promote the creation of iCCM sites and the organization of Family Planning outreach services.

In March 2018, the IMCI (Integrated Management of Childhood Illness) program established a map of iCCM sites. There are 2,899 iCCMs located in the nine provinces. These iCCMs were established by more than six different partners (PROSANIplus, RAcE/IRC, Save the Children, the Global Fund/SANRU, ASF/PSI, MalariaCare), with significantly different packages of operations and levels of functionality. Sustainability of FP initiatives is also a challenge. With Evidence to Action (E2A) and PROSANIplus, USAID has trained and equipped community based distributors (CBDs) of FP commodities in more than 20 ZS. However, since the end of these projects, DHIS2 data indicate that very few CBDs are operational and few report community distribution data on a regular basis.

The expansion of iCCM sites will require capacity building of voluntary CHWs in the community. Coordination of operations must be developed to better harmonize operations of different partners.

Activities:

- Conduct assessment to identify all iCCMs, the services package, and the level of functionality
- Compile and update the content of competency based training tools
- Begin activities to re-energize existing iCCMs in the 9 provinces
- Retrain the CBDs and provide them with kits for continuing basic community distribution
- Recruit and train new CBDs in the zones with difficult healthcare access

IR 2.3 Improved referral system from community-based platform to health centers and reference hospitals.

The PNDS 2019-2022 calls for more attention to effective referrals, i.e. referral and counter-referral between CS and referral hospitals, and considers proper referral combined with integrated supervision to be an important approach towards ensuring comprehensive, integrated and continuous care.

While continuity of care figures among the key principles of primary health care, there are still no clear referral guidelines for CHWs or health care providers in CS, in particular for the referral of tuberculosis, complicated malaria, pregnancy-related bleeding, prescription of antibiotics, and for monitoring of referrals.

In the absence of clear guidelines, CSs, referral hospitals, or ECZS can generate solutions based on findings from DQI processes. Moreover, innovative local solutions can be found by involving communities. This can greatly impact service deliver indicators. USAID IHP has resources to encourage investment, development, operational research, or dissemination at the community level.

Activities:

- Support the development of guidelines for referral and counter-referral systems
- Build referral management capacity within the community and among service providers
- Use mobile phones for follow-up of referrals and to reduce losses of contact
- Use grants to support CBOs in finding innovative solutions to community based emergency transport systems

IR 2.4 Improved health provider attitudes and interpersonal skills at facility and community levels.

Three services in particular are sensitive to the personal or society-based stereotypes, perceptions or misconceptions: 1) obstetric care, when women are vulnerable, dependent and in need of care and empathy, 2) clinical or social services for victims of sexual and gender based violence (SBGV) where

surivivors can report violence or seek care, and 3) youth services, especially when geared towards the particular sexual and reproductive health needs of young people.

Simple and standard quality improvement or quality assurance techniques can help in spotting such provider-related problems. Focus group discussions or participatory techniques such as human-centered design will be used for understanding the roots of such behaviors. But other direct sources of information such as hotlines will be used since they can alert services to the existence of inappropriate practices and trigger case investigations. Based on outcomes of such processes, interventions will be designed to positively influence attitudes and behaviors of health providers.

Properly identified individual-level provider attitudes that constitute barriers to reporting, seeking information, or seeking care can be addressed through trainings, behavior change techniques and coaching.

Training providers specifically in SGBV is essential for dealing with harmful attitudes toward SGBV survivors and ensuring that clients' needs are handled with sensitivity, compassion, and impartiality.

Activities:

- Use participative approaches focused on human-centered design
- Carry out a gender analysis to understand causes of negative attitudes of service providers
- Train service providers according to the gender analysis
- Design hotlines for reporting complaints and carrying out investigations, thus reducing fear of retaliation

IR 2.5 Increased availability of innovative financing approaches.

USAID IHP will strengthen demand-side innovative financing approaches to help reduce cost barriers to service access for the poor and very poor. None of the strategies will solve the underlying problem of systematic underfunding of health services but they will help communities share the financial burden of health care and protect against catastrophic health expenditure.

Before committing to introduce novel initiatives or expand upon existing initiatives, USAID IHP will conduct a landscaping study in each of the regions to identify how and where planned expansion of service delivery and service quality, and increased demand for services will face financial barriers that need to be overcome by the pooling of resources or the purchase of healthcare services through innovative financing approaches.

Initial discussions with USAID on alignment of USAID supply and distribution policies to overall MOH policies has led to exploration of partial cost recovery in health centers and hospitals as the future approach towards sustainable procurement and distribution systems. This innovation will require some focused attention to design implementation strategies and will shift some attention away from the demand-side innovations that were anticipated.

Activities:

- Conduct a landscaping study to explore most promising health financing initiatives that would effectively realize the beneficial effects of increased supply of services and demand for services
- Prepare large scale implementation of cost recovery schemes in public and private health centers and hospitals
- Provide support to Lomami province in strengthening the pilot Mutuelle de Santé project
- Explore use of vouchers with the private sector in Katanga region

- Collaborate with Tanganyika DPS to introduce idea to pilot an emergency fund

IR 2.6 Improved basic facility infrastructure and equipment to ensure quality services.

The healthcare sector is facing a shortage of infrastructure and equipment needed to meet standards. Only 12% of healthcare centers in the DRC are built with durable materials. This situation is due to poor maintenance capability and the lack of maintenance at different levels of the healthcare system.

Activities:

- Implement a program for renovation of health facilities and WASH infrastructure identified by the ECZs and DPS
- Equip renovated healthcare facilities with basic healthcare equipment
- Support the establishment of a biomedical device and equipment maintenance pool within the DPS (via an agreement with a specialized firm)

IR 2.7 Strengthened collaboration between central and decentralized levels through sharing of best practices and contributions to policy dialogue.

At the operational level, and in several areas, good practices are observed; however, they are not disseminated to create and guide policy changes in the healthcare sector. Certain changes in research policies and results are not widespread at the provincial level.

Activities:

- Support technical working groups and task forces to identify good practices for healthcare services that could lead to changes in policies
- Support operational research and disseminate results at all levels

5.4 OBJECTIVE 3

Increase adoption of healthy behaviors, including use of health services, in target zones de santé

USAID IHP will work with provincial structures to help them address factors such as low community awareness and knowledge of health services and pervasive cultural and gender norms that are barriers to health-seeking behaviors.

Community mobilization will build demand for quality health services, increase community engagement and generate social support to enable and incite healthy behaviors. More robust household and individual behavior change efforts are thus needed to increase health-seeking behaviors and improve health outcomes. USAID IHP will support provinces and ZS to conduct activities that focus on people's needs and spotlight demand for services by promoting behavioral and attitudinal change.

To tackle these challenges, the program's SBC interventions cover a range of options for reaching target populations. This year, USAID IHP will develop a core campaign for target regions, informed by the program's nuanced understanding of on-the-ground realities and the development of appropriate messages. One example is the Healthy Family Campaign (HFC), which will use existing platforms with a broad reach in DRC to disseminate messages, including television, radio and mobile phones. The HFC is a multi-pronged entertainment education program based on the HCD behavior change cycle, which features a serial family drama with relatable characters adopting healthy behaviors. Using USAID's

accelerator behaviors[5] as the focus, the drama will feature recognizable characters who face common barriers to better health outcomes across the program's intervention areas and through different media.

To contextualize the umbrella campaign, USAID IHP will work with existing community structures—including CHWs and their networks—as part of the GUC mechanism in targeted ZS. Using grants will help CSOs reach women's associations and other community groups. Informed by the project's HCD approach, activities will vary by community. USAID IHP will also coordinate and collaborate with other key USAID implementing partners, such as Breakthrough Action.

Other program interventions will include support of community-based SBC interventions; capacity-building of ECZSs, CODESAs and CHWs to engage with communities and use "pull" techniques, such as open houses and individualized text messaging, and a Key and Vulnerable Populations Champion Communities framework to incentivize health-seeking behavior. On the technology side, the program will use mobile surveys for research and monitoring of socio-cultural barriers, and mobile messaging to make information available through the toll-free 155 service, stimulating demand through mHealth.

The program's reinforcing Intermediate Results (IRs) contribute to strengthened governance, increased coverage, and utilization of quality health services and adoption of healthy behaviors. For example, improved management and motivation of human resources for health (IR1.6) is a necessary component for improved health provider attitudes and interpersonal skills at facility and community levels (IR2.4).

In line with USAID knowledge management principles, USAID IHP will actively participate in several Technical Working Groups (TWGs) on malaria, WASH, nutrition, and RH/FP. The program will share technical inputs, discuss policy, and provide inputs on technical guidelines and other programmatic tools.

5.4.1 OBJECTIVE 3 INTERMEDIATE RESULTS (IRS) IN BRIEF

IR 3.1 Increased practice of priority healthy behaviors at the individual, household, and community levels.

Actions for social and behavioral change will be aimed at individuals and the community to encourage the adoption of positive behaviors, create changes in the social and structural environment, and contribute to better individual, family, and community health results. USAID IHP will examine messages to ensure that they are sensitive to conflicts and will distribute them via traditional channels to maximize impact.

To this end, USAID IHP will collaborate with the Accès Aux Soins de Santé Primaires (ASSP), the President's Malaria Initiative (PMI), and other donors/humanitarian aid entities to harmonize and streamline efforts in Communication pour le Changement de Comportement (CCC) and zones, and ensure that the SBC tools are preferentially used in provinces that have contributed the least to behavioral changes in the recent past.

Our belief is that the program will help the provinces train and support the staff of DPS, ECZSs, CODESA, CAC, and Organization à Assise Communautaire (OAC) to carry out quick participatory assessments using tools such as Pathways to Change, mapping, and structured discussions.

Activities:

- Launch Healthy Family Campaigns (HFC) in the provinces of Tanganyika, South Kivu, Lualaba

[6] WHO & International Center for Equity in Health. State of inequality: reproductive, maternal, newborn and child health, WHO 2015.

- Support the distribution of key awareness raising messages to prevent diseases such as cholera, TB, MNCH, FP, malaria, WASH, nutrition and pneumonia
- Every quarter, support mini CCC campaigns on FP, TB, MNCH, malaria, nutrition, and WASH for vulnerable groups in the target sites (such as minors, refugees, internally displaced persons and transportation providers) in two ZS per province (Haut Katanga, Tanganyika, Kasai central, Kasai Oriental, Lualaba)
- Support the continued functioning of Champion Communities existing within the provinces of Lomami, Lualaba and Kasai Central

IR 3.2 Increased use of facility and community-based health services.

USAID IHP will collaborate with international relief agencies and other donors to help improve use of healthcare services according to the standards and directives of the MOH within the framework of the development approach.

The program will collaborate with the DPS to prioritize services to be promoted according to disease profiles and quality improvement plans (e.g. nutrition activities in South Kivu, the prevention of malaria in Kasai Central, family planning and combating tuberculosis in Haut Katanga). The program will improve awareness building activities to promote the services available and overcome obstacles to their access. To this end, it will use innovative mass communication and social and behavior change techniques to encourage positive behaviors when it comes to seeking care. The effectiveness of each campaign will be measured by using appropriate indicators.

USAID IHP will pay special attention to illnesses related to youth, gender, and stigmatization in the community and the contribution of healthcare professionals to improvement of use and improvement of services.

Activities:

- Organize open houses within healthcare establishments
- Distribute information through community networks such as CHWs, CODESA, schools, churches, other CBOs, private sector provider associations
- Use personalized messaging on Viamo based on pre-established directories
- Organize multimedia campaigns using the HFC platform and focused on service in the healthcare center and at the community level, including active research of cases through community monitoring

IR 3.3 Reduced socio-cultural barriers to the use of health services and the practice of key healthy behaviors.

USAID IHP will work with Breakthrough Action and other partners to carry out qualitative and participatory research to explore social norms related to priority healthy behaviors. It will support the PNCPS (Program National de Communication pour la Promotion de la Santé (National Communication Program for Health Promotion)) in the revision of key messages and update of scenarios related to provincial characteristics (e.g. polygamy, sexist violence, and gender norms) that create obstacles to responsible family behaviors.

To this end, the program will focus on the involvement and active participation of community members and leaders in small group discussions of 10 to 15 people, to analyse barriers and determine actions to be implemented.

Activities:

- Support the organization of a provincial workshop on the identification of socio-cultural barriers to healthcare services and behavior change in five ZS per region
- Provide technical assistance to 15 ECZSs to map the main influencers and draw up an engagement plan
- Provide technical and financial support for 50 community discussions per region on the promotion of health

IR 3.4 Strengthened collaboration between central and decentralized levels through sharing of best practices and contributions to policy dialogue.

Coordination and collaboration are key elements for successful implementation of the program. USAID IHP will work with the departments of the MOH in charge of community participation activities and CCSC (DGOSS and the PNCPS) to harmonize SBC strategies and share lessons learned. Activities will include participation in TWGs and whenever possible, attendance at work meetings and participation in conferences and reviews. We will also work closely with Breakthrough Action to coordinate SBC activities and develop the best messages and channels for policy dialogue and for informing centralized and decentralized levels of their mandates, opportunities and roles.

Activities:

- Write success stories to motivate and inform DPS and ZS in their new roles
- Support meetings for the development of community activities and sharing lessons learned every six months (at the national and provincial level)

6. OVERVIEW OF TECHNICAL AREAS

6.1 MALARIA

WHO estimations indicate that from 2010 to 2015, the number of cases in the DRC decreased from 28 million to 19 million, representing a drop of approximately 32%, while deaths fell from 82,000 to 40,000, a decrease of 49% (WHO 2016). Despite significant progress in malaria prevention and control, the DRC remains an important contributor to global mortality and morbidity figures. In 2015, DRC and Nigeria combined, contributed to 38% of worldwide malaria morbidity and 36% of malaria mortality (WHO 2016).

The Plan Stratégique National (PSN) 2016-2020 divides the country into four categories based on the prevalence of the parasite: category I with prevalence ≤5% corresponds to the mountain areas; category II with prevalence between 6 to 30% corresponds to the equatorial and tropical areas. It covers 15 DPSs, including South Kivu, Haut Katanga, Haut Lomami, Kasaï Orientale and Sankuru. Category II b, with prevalence of about 8.1% with variation between downtown and the outskirts of town, consists of Kinshasa province only. Category III, with a prevalence of ≥30% (31-55%) corresponds to the tropical area, and contains the Lualaba, Kasai Central, Tanganyika and Lomami provinces.

Following the Program Performance Review of the PSN 2013-2015, the following weaknesses were detected at DPS levels (including those DPS supported by the program): lack of advocacy plan on data on the partial or former socio-economic burden, lack of a management plan for vector insecticide resistance, lack of sustainability of routine long-lasting insecticidal nets (LLIN) distribution, limited capacity in entomology and vector control, limited application of national treatment guidelines, frequent and extended shortages of anti-malarial stocks. Recommendations were formulated to address these weaknesses.

The general objective of the PSN 2016-2020 is to reduce the morbidity and mortality rates linked to malaria by 40% with respect to those of 2015. The strategic objectives are to protect at least 80% of people exposed to the risk of malaria through preventive measures by 2020; test at least 80% of cases of fever suspected to be caused by malaria and treat 100% of persons testing positive according to national guidelines by 2020; improve the monitoring and evaluation system by 2020; raise awareness among at least 75% of the population exposed to malaria about modes of transmission, prevention, and treatment by 2020; and improve program management by 2020. The main strategies are malaria prevention, treatment of cases, epidemiological monitoring, communication for behavior change, and program management.

The main current problems are frequent and extended shortages of stocks of antimalarial drugs, limited access of households to services in healthcare facilities, failure to ensure the sustainability of distribution of LLIN on a routine basis, and limited vector control capacities.

Each year since 2016, the PNLP establishes annual operational plans for implementation of the PSN 2016-2020. The implementation of the PSN requires the mobilization of adequate resources by technical and financial partners. Following this process, advocacy with partners resulted, for the first time in the DRC, in total coverage of the ZS with the support of the PMI for the fight against malaria.

The national strategic plan for the Malaria Control Program 2016-2020 focuses on the following strategies:

- Vector control, including the distribution of LLINs through mass campaigns every three years and routine distribution during prenatal care visits to pregnant women at their first visit to the ANC and to children completely vaccinated in the routine Expanded Program on Immunization (EPI), and school based distribution of Insecticide treated nets (ITNs)
- Indoor spraying, which is currently done on a very small scale in two ZS supported by mining companies
- Intermittent preventive treatment with sulfadoxine/pyrimethamine (SP), provided to pregnant women after their first trimester of pregnancy at the four recommended ANC visits
- Intermittent preventive treatment and seasonal malaria chemoprevention are both included in the national strategic plan as potential procedures, but are currently not implemented
- Management of cases of malaria and drug resistance, using diagnostic tests for suspected cases of malaria using the rapid diagnostic test (RDT) or microscopy. Confirmed cases must be treated with artemisinin-based combination therapy (ACT), artesunate/amodiaquine (AS/AQ) or artemether/lumefantrine (AL) for uncomplicated cases and injectable artesunate or quinine for severe malaria. The strategy also includes rectal artesunate for preferential treatment for the orientation of community healthcare sites toward centers.
- Monitoring and evaluation and operational research via the national health information system (DHIS), routinely with the DHIS2 software, weekly monitoring integrated with notification of diseases with epidemic potential (MAPEPI) and epidemiological and entomological monitoring
- Communication for social and behavior change implemented via interpersonal and mass communications, in collaboration with the national health communication program, the national health program in schools, and community organizations

In 2016, the PNLP and its main funders of the fight against malaria decided to better coordinate their efforts and to target their efforts in concentrated geographic zones while eliminating overlaps in provinces. Thus the PMI now covers nine provinces and 178 contiguous ZS located in the southwest of the country. The other provinces are covered by the Global Fund and the DFID.

PMI works with implementation partners to implement actions in the fight against malaria:

- MEASURE Evaluation in monitoring and evaluation
- Global Health Supply Chain-Technical Assistance: Mass LLIN campaign, supply of drugs
- Impact Malaria: in malaria microscopy and quality control
- USAID IHP: in routine distribution of LLINs, intermittent preventive treatment, malaria case management and management drug resistant cases, communication for social and behavior change

USAID IHP activities of the Malaria Operation Plan (MOP):

1. Vector control: Routine distribution of LLINs during ANC and EPI in the 178 ZS of nine provinces, to reach at least 85% of pregnant women who have completed at least one ANC visit and at least 70% of children vaccinated against measles, i.e. meeting criterion of being fully immunized.
2. Malaria during pregnancy: The national strategy for prevention and treatment of malaria during pregnancy in the DRC follows the three components of the WHO recommendations: prevention with LLIN, Intermittent Preventive Treatment (IPT) (with SP) and rapid and effective treatment of malaria in pregnant women. The national guidelines for IPT were revised in 2013 to reflect the WHO recommendations. The DRC recommends that the first dose of IPT be administered at the beginning of the second trimester (between the 13th and 16th week). The DRC also revised its guidelines for the treatment of malaria, including in pregnant women. In 2017, in the nine provinces, approximately 70% of pregnant women received two doses of SP and 65% received three doses. To improve the treatment of malaria during pregnancy, USAID IHP will implement the following actions: work with RH to revise Médecin Inspecteur Provincial (MIP) guidelines to align with most recent WHO guidelines, supervision, training, refresher training so that providers know the guidelines and the schedule for IPT, provision of a water jug/filter and glasses to allow the providers to directly observe the administration of the SP, organization of Healthy Family Campaigns to improve the use of ANC services, and improvement of adequate and effective coverage with IPT (refer to Tanashi model with a cohort of pregnant women from IPT 1 to at least IPT 4).
3. Management of malaria and pharmacoresistance: USAID IHP support will target the two levels of the health system. At the community level, retraining of CHWs will provide the iCCM sites with renewed capacity to diagnose malaria based on rapid tests (RTs), to treat the uncomplicated cases of malaria with ACT and to refer severe cases to the health centers while administering rectal artesunate (suppository). At the health center level, we will work with the MOH to intensify malaria treatment capabilities in the public and private sector by dissemination of standards and promote availability of products and strengthening of technical capabilities.
4. Providers: Use of RDT for malaria diagnostic before treatment and adherence to negative RDT result.

6.2 TUBERCULOSIS (TB)

Tuberculosis remains a major public health problem in DRC. According to the 2017 WHO report, only 51.8% of the estimated cases of tuberculosis, all types combined, are detected. The tuberculosis problem is compounded in DRC by TB-HIV co-infection, but also by the emergence of bacillus strains at different degrees resistant to first- and second-line TB drugs.

The MOH, through its National Program to Combat Tuberculosis (NPCT) and its partners, initiated a resource rationalization process that aims at a better coordination of interventions, especially when

different partners are present in the same provinces, in the same zones or even the same sites. Partners are now committed to provide a full package of TB services.

Two USAID implementing partners support TB activities: Challenge TB and USAID IHP. Support is provided to the Central Unit at national level, and at the intermediate and operational levels in the nine provinces. USAID IHP will quickly finalize the discussions with TB Challenge and Fondation Damien in order to come to a consensus on the ZS and type of activities that each of the three partners will be supporting in the nine USG-assisted provinces. USAID IHP will collocate and collaborate with Challenge TB to provide a package of TB services in five provinces (Lomami, Kasaï, Kasaï-Oriental, Sankuru, and Sud-Kivu) where Challenge TB already works.

In those provinces, USAID IHP will be in charge of strengthening the Diagnostic and Treatment Health Centers (Centres de Santé Diagnostique et Traitement (CSDTs)) and increasing their geographical coverage (i.e. working towards national targets), transportation of samples, intensification of screening in children, collaborating with civil society organizations especialy Club d'Amis Damien (CAD) in order to reach and trace the TB case-index contacts. In those provinces, Challenge TB is in charge of TB activities in prisons, providing nutrition and supporting laboratory pre-treatment analysis and follow-up for Multidrug-Resistant/ Extensively Drug-Resistant (MDR/XDR) TB. In the four other provinces (Lualaba, Haut-Lomami, Haut-Katanga, Tanganyika), USAID IHP will collocate and collaborate with Fondation Damien. In these provinces, USAID IHP will be in charge of TB activities in high volume prisons, transportation of samples, intensification of screening in children, supporting laboratory pre-treatment analysis and follow-up for MDR/XDR TB patients. USAID IHP and Fondation Damien will coordinate on nutrition support for MDR/XDR TB patients.

A consensus between USAID IHP and each of two partners (TB Challenge and Fondation Damien) is in terms of the number/ list of the ZS and the type of activities that each of the three partners will be supporting in the nine U.S. government-assisted provinces.

In the spirit of the rationalization pursued by the MOH, the Global Fund and USAID, USAID IHP will continue to support activities in Haut Katanga that were formerly supported by the Global Fund. These catalytic activities were targeted at missing cases, and the intention was to identify and recruit those cases in innovative interventions of screening, diagnosis and treatment in special populations, such as prisoners, miners or children. These activities will be continued.

6.3 MATERNAL, NEWBORN AND CHILD HEALTH (MNCH)

Maternal, newborn and child health is the prominent theme in the results-oriented priorities of the new PNDS 2019-2022. The maternal mortality rate is of 846 deaths per 100,000 live births and the neonatal mortality rate is 28 deaths per 1,000 live births. Over the first half of 2018, the DRC registered 3,656 maternal deaths of which 1314 (36%) occurred in health facilities and 2342 (64%) in the community, and 41% (1,515) were in the nine provinces supported by USAID IHP (Bulletin N°1 de la Surveillance des Décès Maternels et Riposte Janvier-Juin 2018, République Démocratique du Congo (RDC)). The most affected provinces among the nine DPS are Sud-Kivu (361) and Haut-Lomami (254); note that Sankuru has many non-reporting ZS (12/16) where data is irregularly or never reported. The United Nations Inter-agency Group for Child Mortality Estimation (IGME) report (IGME 2017) indicates that the neonatal mortality rate has experienced a rebound to 30 per 1,000 Live Births (LBs) in 2016. Among children younger than 5 years, more than 300,000 deaths occur each year. Certain provinces such as Sankuru, Haut-Katanga, Kasaï-Central, Kasaï-Oriental and Lomami, experience child death rates above the national average. The Improved Monitoring Action 2016 shows that only 21% of clinical service providers offer quality care based on the Prise en Charge Intégrée des Maladies de l'Enfant (PCIME) strategy.

The program will contribute to training on Maternal Death Surveillance and Response (MDSR) to identify, notify, analyse and respond to maternal death at the facility and community levels, in the Sud-Kivu and Tanganyika provinces in particular. Given these priorities, USAID IHP will assess intervention needs during its first year of implementation, and will work with provinces to define training needs and equipment needs.

USAID IHP will support implementation of high-impact Emergency Obstetric and Newborn Care (EmONC) activities, essentially focused on Active Management of the Third Stage of Labor (AMTSL), management of persistent post-partum hemorrhage in women who have or have not benefitted from AMTSL, pre-eclampsia care and neonatal resuscitation and post partum care. The activities will continue in the 12 ZS (Dibaya, Ndekesha, Bilomba, Luiza, Bibanga, Kanda-Kanda, Mwene Ditu, Katana, Nundu, Fungurume, Kanzenze, Mutshatsha) that have already integrated EmONC and be extended to 20 new difficult-to-access ZS that do not currently benefit from many interventions and register more deaths (Sud Kivu, Tanganyika, Kasai Oriental and Lomami). The objective is to fully cover the 60 ZS.

With respect to newborns, the activities will essentially pertain to the management of neonatal sepsis by the administration of antibiotics, implementation of Helping Baby Breathe initiatives to address newborn asphyxia, and the management of babies of low birth weight in the provinces of Sud-Kivu and Lualaba.

USAID IHP will support the implementation of the refocused antenatal care package in health facilities according to the national guidelines, and organize Healthy Family Campaigns to improve the use of ANC services.

Ordinograms of care at the health center, and clinical and therapeutic guides for services at the general referral hospitals will mainly be implemented in the Kasaï region where the infant mortality rate remains high, exacerbated by the crisis of the last two years.

A map of iCCM sites developed in March 2018 established that there are about 2,899 iCCMs located in the nine provinces established by more than six different partners (PROSANIplus, RAcE/IRC, Save the Children, the Global Fund/SANRU, ASF/PSI, MalariaCare), with significantly different packages of operations and levels of functionality. USAID IHP will conduct an assessment to identify all iCCMs, the package of services provided, and the level of functionality.

Faced with the persistence of a large number of children not vaccinated for all antigens, and the resurgence of vaccine-derived poliovirus (VDPV) , Measles and Yellow Fever, the EPI program proposes to implement from October 2018 onwards, an emergency plan for the relaunch of routine vaccination called "Mashako Plan on Routine Vaccination". The plan aims to increase vaccine coverage by 15% by implementing a strategy to reach every child for the next 18 months and will be implemented in nine provinces, 3 of which are supported by USAID (Haut-Katanga, Haut-Lomami and Tanganyika). USAID IHP will continue the effective implementation of the Reach Every Child (REC) strategy, in addition to the Mashako plan, in 6 other provinces (Sud Kivu, Sankuru, Kasai Oriental, Kasai Central, Lomami and Lualaba).

In Sud-Kivu and Tanganyika provinces, due to the long-standing armed conflict, the post-exposure prophylaxis (PEP) kit will be available thanks to collaboration with GHSC-TA which handles its procurement and distribution.

6.4 FAMILY PLANNING/REPRODUCTIVE HEALTH

Recent studies have shown low integration of family planning services in most ZS. Health zones in the ex-province of Katanga (Haut-Lomami Tanganyika, Lualaba and Haut-Katanga) are among those with the lowest contraceptive prevalence (3.5%) compared to the country overall (8%). The 3rd National Conference for the Repositioning of Family Planning recommended increased access to family planning services, for men and women, in the public as well as in the private sector. USAID IHP will help

provinces achieve this goal by supporting community-based distribution of contraceptives, integration of FP services in all health facilities, and by supporting scaling up of youth and adolescent reproductive health services in a wide range of community based structures such as parishes, churches, NGOs, associations and clubs. Some activities have already been implemented in Sud-Kivu and in Lualaba in USAID IHP's predecessor program.

USAID IHP will build on existing service provision, and will continue to invest in competency-based training of facility-based and community-based providers. In several places, material and equipment for CBDs needs to be renewed and CBD kits will thus be provided. The program will procure bicycles so that CBDs can reach households wherever they are, can do home visits and case follow-up, and also to ensure that supervision during outreach activities can take place.

Within the first year, a particular effort will be made in Tanganyika and Haut-Lomami provinces to improveintegration of a family planning package. In other provinces, the DPS will be encouraged to undertake an in-depth assessment of the causes of low contraceptive prevalence so that activities can be better targeted. The three-pronged approach of the FP and RH activities consists of the following:

i. Service delivery: Include a thorough assessment of service delivery gaps and demands during the initial mapping of the services in the nine provinces. Mindful of E2A's expansion of activities (15 ZS), USAID IHP will focus on quality of FP services at community and facility level and in particular, sustain achievements by re-training health workers and community health workers trained under previous programs (PROSANIplus and E2A), as well as integrating FP in the iCCM sites.
ii. Coordination support: Provide strong support to the Permanent National Multi-Sectoral Committee (CTMP) at national and provincial levels, including by providing financial support at the provincial level.
iii. Supply chain: When essential drugs are in shortage, reaction is immediate except when FP products are out of stock. USAID IHP will therefore raise the level of altertness about availability of commodities.

Activities:

- Capacity building for the members of Equipe Provinciale Polyvalente (EPP) and the coordination PNSR in the new DPS (Lualaba, Tanganyika, Liomami, Haut Lomami and Sankuru) to develop the skills to oversee and coach the ZS and health facilities to implement FP activities
- Training for providers on FP in 5 ZS of Tanganyika
- Retraining for provider and community-based distribution of FP commodities (CBD) in 20 ZS where PROSANIplus and E2A projects provided training between 2015 and 2017
- Provide CBD kits in the 20 ZS
- Provide a mix of FP methods at all health facility levels
- Organize FP outreach strategies with CDBS (building on E2A experiences)
- Provide integrated supervision that takes into account the US compliance requirements for the provision of FP services
- Provide training of trainers for youth-friendly health services in South Kivu, Kolwezi, Haut Katanga provinces
- Train youth and adolescent peer educators on youth-friendly services in Kasai Central

6.5 NUTRITION

USAID IHP's nutrition strategy aligns with the USAID Nutrition Guidelines to strengthen DRC's capacity by advancing supportive nutrition and food security policies and improving nutrition information

systems while increasing availability and use of proven nutrition interventions to reduce mortality, morbidity, and food insecurity. The nutrition strategy also aligns with the National Nutrition Policy 2000, the 2013 National Nutrition Policy and the Multi-Sectoral Strategic Plan of Nutrition 2016-2020.

The USAID IHP nutrition strategy aims to reduce under-5 mortality. Nutrition-related factors contribute to about 45 percent of deaths in children under five years of age. In health facilities, nutrition activities are part of the minimum package of care, including the promotion of proper nutrition, and the detection, prevention and treatment of malnutrition in women and children under five. In community-based programs, health volunteers interact with households to encourage good nutrition practices as well as to facilitate access to malnutrition treatment.

The programming aim for nutrition is thus to support the DPS and ECZS to increase the availability of essential facility-based health services as well as to increase the capacity of CHWs to detect, treat, and prevent malnutrition in communities. The program will also focus strongly on reinforcing governance and leadership of DPS and ECZS in order to improve functioning of different coordination frameworks at provincial and zonal levels, and strengthen their capacity for monitoring and supervision of nutrition programs at the community and health facility levels.

The nutrition component will also tackle undernutrition and help mitigate the risk of undernutrition among targeted populations. The intervention will emphasize nutrition specific activities at the critical time between the start of a woman's pregnancy and her child's second birthday through promotion of optimum IYCF practices and treatment of severe acute malnutrition. Nutrition sensitive activities through food security and WASH activities (in addition to those of USAID IHP) will also be covered by others donors such as FFP.

Prior to organizing nutrition interventions, USAID IHP's nutrition expert will conduct an assessment of on-going nutrition activities in health facilities to determine the current capacity to manage preventive and curative nutrition activities. This will cover the Maternal and Infant and Young Child Feeding (MIYCF) counselling activities for pregnant and lactating women, the synergies between the MIYCF activities and RH and FP services as well as the quality of the Community Management of Acute Malnutrition (CMAM) services (outpatient treatment for severely malnourished children and supplementary feeding programs for moderate malnourished children), including community outreach activities.

Based on the results of the health facility capacity assessments and using a cascade methodology, USAID IHP will provide direct support to the key actors (DPS and ECZS) through MIYCF and CMAM training, coaching, tools, materials, and a monitoring system, so that they can replicate these actions in ZS and in communities based on their ZS annual action plans. The program expects to target more intensive work in approximately 60 ZS and to target health facility workers and community actors connected to these health facilities.

As part of the baseline, the exclusive breastfeeding indicator for children of 0-5 months will be monitored. We will also assess the barriers to optimal MIYCF practices through focus group discussions and interviews with relevant informants. The results will be used to adapt the MIYCF strategy, and will serve as a baseline to evaluate midterm and end-of-project impact on exclusive breastfeeding.

Multiple channels will be used to influence women's MIYCF practices by targeting health facility workers and community actors. Repetition of key messages will be one strategy to ensure that the community hears the same MIYCF messages and that these translate to the desired attitude, practice and behavior changes at the individual and household levels. In order to achieve this, at health facility level, MIYCF sensitization and counselling will be reinforced in all services for pregnant and lactating women as well as children under five, including ante-natal care, delivery, post-natal care and vaccination services.

At the community level, nutrition education will raise awareness of breastfeeding and complementary feeding, and will target community leaders to deliver messages at the community level. Mother to

Mother Support Groups (MtMSG) will be strengthened. Each health facility will have a minimum of one MtMSG in the community that it serves and each MtMSG will be composed of 5-12 facilitators who deliver MIYCF counselling sessions either individually or in groups.

In addition, the project will support regulation of unsolicited donations of breast milk substitutes to abide with the International Code of Marketing of Breast Milk Substitutes at all health facilities.

6.6 WATER, SANITATION AND HYGIENE (WASH)

The adequate supply of safe water and basic sanitation is one of the components of primary health care, which is operationalized at the level of the ZS. The program will therefore focus on implementing water points, latrines and handwashing points in three ZS of Kasai Oriental, two ZS of Kasai Central, two ZS of Lomami and two ZS at South kivu. This choice is justified by the fact that Kasai (Kasai Oriental, Kasai Central and Lomami) and eastern Congo (South Kivu and Tanganyka) regions are facing recurring cholera outbreaks. For the past 10 years, Bukavu and Kalemie have been identified as source areas (WHO 2009), and Tanganyika is experiencing a cholera outbreak this year. According to OCHA, 25,170 new cases and 857 deaths were recorded in this province, as of October 28, 2018, while the DPS Kasai Oriental reported 5,354 new cases and 267 deaths between February and September 2018. The September 2017 cholera response plan of DPS South Kivu reported, 4,970 cases and 28 deaths in the first 35 weeks of 2017.

For this first year, five types of activities are to be implemented in the targeted communities.

Activities:

- Rehabilitate/renovate WASH facilities: The program plans to rehabilitate 50 water points and 300 latrines + handwashing points in targeted HZ communities. USAID IHP will gather and use the experience gained through other WASH projects funded by USAID (including Food for Peace projects implemented by CRS in Kasai and Merci Corps in South Kivu) and other WASH stakeholders/partners, such as Service National d'Hydraulique Rurale (SNHR), Comités Nationale d'Action de Eau, Hygiène et de l'Assainissement (CNAEHA), the MOH Disease Control Directorate and the MOH Directorate d'Etudes et Planification (DEP). The expected result is 38 water points and 155 latrines + handwashing points in targeted ZS communities.

#	Provinces	Health Zones	Water points	Latrines
1	Sud Kivu	1	05	30
2	Kasai Oriental	3	10	60
3	Lomami	2	18	40
4	Kasai Central	2	5	25
	Total	**8**	**38**	**155**

  - USAID IHP is in the process of working with provincial directors and DPS to determine the ZS and with CRS on the consultation framework. In fact, the draft TDR consultation framework USAID IHP/Budikadidi was submitted to CRS for advice and inputs. South Kivu ZS that have already benefited from USAID investments will not be targeted, and WASH technicians in communities and FOSA level with be trained to be able to contribute to training activities during implementation. This activity will only have a technical focus and will take place where the operations of the different target groups are located, to allow for adaptation on the job. It will

be organized and conducted by the ZS supervision teams and community animators with support from the central, regional and DPS levels.

- Needs Assessment: This activity will consist of implementing WASH needs assessment workshops in the six provinces that will be fully supported, and on providing training on the tool and data collection in health areas. The needs assessment questionnaire will integrate aspects related to water resources; the quality of the water; sanitation; waterborne diseases; hygiene; aspects relating to sociocultural factors, beliefs and practices and community water management.
- Prioritization, phasing and development of implementation plan: USAID IHP will support workshops for the DPS to prioritize in which ZS and when interventions will take place in order to develop an implementation plan. The expected result is for each DPS to have a provincial WASH plan that is utilized by the partners.
- Implementing the Community Empowerment Process: This activity directly affects the sustainability of the systems, and includes the management of a process of empowerment and an investment in human resources to create management structures. The process consists of an organizational scan of the structures and putting in place a support plan to enable empowerment. The program will ensure that the autonomous communities integrate the "life cycle cost" in the design of the management system to ensure the continued functioning of the water supply, hygiene and sanitation services. Activities related to community mobilization (objective 3) will focus on the dissemination of the water law and assist in the design of messages for awareness-raising activities on the prevention of water-borne infections (cholera) in the eastern region of Congo, and WASH promotion in general in the Kasai region (except Sankuru) to improve the practice of healthy behaviors. These messages will be translated into local languages and will take into account sociocultural factors and perception at the community level.
- Collaboration: To implement the WASH component, USAID IHP will maintain effective collaboration with the central level for its normative and regulatory role, and with the DPS given its role of technical supervision, monitoring and facilitation of the implementation of actions in targeted ZS. During implementation, emphasis will also be placed on the sustainability of learning outcomes; synergy and collaboration with other WASH and sector projects; the clarity and consistency of WASH promotion messages to be incorporated into MNCH services; integrating infection prevention and control measures into provider training; promoting citizen mobilization around the general sanitation of villages; promoting hygiene measures; and supporting awareness raising on waterborne diseases (media elements and awareness campaigns).

7. CROSS-CUTTING AREAS

7.1 GENDER

Gender-related inequalities and disparities disproportionately compromise the health of women and girls and, in turn, negatively impact families, communities, and health and development outcomes. A 2015 WHO report on health inequality revealed that, overall, inequalities most affect women, infants, and children in

disadvantaged population subgroups; the poorest, the least educated, and those residing in rural areas had lower health intervention coverage and worse health outcomes. [6]

Gender equality between men and women and boys and girls—encompassing attitudes, norms, and behaviors in all societies and communities—is a key development objective and essential to achieving health and sustainable development outcomes. Available evidence suggests that challenging harmful gender norms and addressing gender barriers can lead to better outcomes and address a broad range of health challenges including-decision making, mobility, and access to resources.

Throughout its interventions, USAID IHP will pay special attention to gender inequalities that present barriers to equity in the health system. The team will implement all interventions with a view toinstitutionalizingn and sustaining gender equality. Drawing on the gender analysis that the program will conduct in Year 1 and MOH DQI results, IHP will design a toolkit for clinical care of SGBV survivors and explore ways for women to report abuse safely. These items are more broadly covered in the Gender Analysis and Gender Implementation Strategy (submitted to USAID on Nov 2, 2018, revision to be submitted on Nov 30, 2018).

7.2 CONFLICT SENSITIVITY

To mitigate/manage conflict, the program will ensure interventions are based on an understanding of local contexts. USAID IHP will draw on the results of its conflict sensitivity analysis (submitted on September 6, 2018, revision submitted on Oct 11, 2018) to inform implementation and avoid putting personnel at risk while promoting access to services. The initial report will provide background and updated research on conflict issues and sensitivities in our target provinces. USAID IHP will follow this with training and awareness building to incorporate learnings into our programming, ensuring a "do no harm" approach, understanding possible negative impacts, and maximizing positive impacts of activities with these sensitivities in mind. This analysis will also address the relationship between health and conflict, and provide guidance to mitigate adverse impacts on health services based on conflict and tensions, especially in emergency situations. USAID IHP will update this report annually and include it in work planning activities.

7.3 CAPACITY BUILDING

Excerpts from the Executive Summary of the Capacity Building Approach report, submitted to USAID on October 5, 2018, are provided below for easy reference.

Institutional reforms in the DRC have increased the number of provinces or units (including Kinshasa) from 11 to 26 and increased the number of authorities within these entities. USAID IHP will support the decentralization process through institutional strengthening of the health system, working with and through the MOH to reinforce and build its capacity to implement its envisioned decentralized organization, systems, and personnel. The strengthening of institutional capacity cuts across all objectives of USAID IHP and is an essential element of the program's sustainability strategy.

USAID IHP will implement an institutional capacity-building approach that will:

[6] WHO & International Center for Equity in Health. State of inequality: reproductive, maternal, newborn and child health, WHO 2015.

- Strengthen the DPSs in the nine focal provinces so they can function effectively as strong and effective organizations. To do so, they will use core MOH management systems and procedures in planning, reporting, coordinating, oversight, and financial management.
- Strengthen the institutional capacity of the 178 ZS and health facilities so they can carry out their core functions, which are managerial, service delivery-oriented, or community development-oriented. This includes collaboration with CODESAs and health committees, and coordination of the activities of key stakeholders, including private sector providers.
- Build the capacity of organizations that are part of the health system or partners to the health system. This includes community structures such as the CODESAs, other community-based organizations and private sector health care providers. For community structures, USAID IHP will also reinforce their ability to interact with MOH institutions and to foster accountability of the MOH institutions to carry out their functions effectively.
- Develop and strengthen individuals' technical knowledge, service delivery and management skills to enable the systems and organizations to provide improved health services.

USAID IHP proposes a broad framework for the institutional capacity building (ICB) approach in which capacity building is defined as the process through which individuals, organizations, and societies obtain, strengthen, and maintain the capabilities to set and achieve their own development objectives over time (UNDP). Our capacity building approach is:

- **Grounded in organizational development.** Together with stakeholders, we will jointly develop a comprehensive view of what it takes to be a functioning organization and create capacity strengthening plans based on institutional assessments.
- **Aligned with MOH's priorities and processes.** In all program activities, USAID IHP will work through and reinforce MOH systems, thereby supporting the ongoing reform process.
- **Part of an integrated system including CODESAs, zones de santé, and DPS.** Interventions, while geared towards meeting the needs at each level within the MOH, must be implemented in an integrated manner and coordinated with other projects and donor activities.
- **Assessment- and data-driven.** Prior to conducting interventions, USAID IHP guides the MOH entity to conduct a self-assessment and to plan organizational development activities. The outcomes of the self-assessments inform the design of tailored capacity-building interventions.
- **Outcome-driven.** The emphasis of our capacity building is on moving institutions to focus on performance to achieve desired outcomes and proper implementation of core functions.
- **Inclusive of intangible factors.** USAID IHP will work with the MOH to reinforce all aspects of a well-functioning organization, including ensuring attention to intangible areas that typically receive less attention (such as social skills, experience, creativity, social cohesion, social capital, values, motivation, habits, traditions, institutional culture).

7.4 METHODOLOGICAL APPROACH

A four-stage methodology describes the overall flow of the USAID IHP institutional capacity building:

- Organizational assessment, using the Participatory Institutional Capacity Assessment and Learning Index (PICAL) tool, identifies management and performance gaps, allowing us to develop a customized capacity-building plan for each institution.
- Strengthening of the institution is based upon this capacity-building plan, which identifies performance gaps and interventions to overcome them.

- Application of newly acquired skills and competences requires real-time, frequent application of new skills that embeds them in behaviors for sustained impact.
- Achievement of outcomes requires constant reinforcement and buy-in from management, as well as a critical mass (tipping point) of individuals adopting the behaviors.

7.5 STRATEGY

USAID IHP will build on the Health Finance and Governance (HFG) capacity building strategy successfully applied in Haut-Katanga and Lualaba provinces to expand coverage to the other provinces, their ZS, and corresponding community levels. A key element of this strategy is continuous staff development within USAID IHP to promote the mindset and skills needed to achieve program goals by working within the organizational frame and systems of the MOH. The USAID IHP approach to capacity development will be implemented at the individual, organization, and system levels:

Individual: We will develop the public health competencies and management skills of individuals, increasing staff knowledge and implementation of organizational systems at the DPS, ZS, and community levels to support the MOH's organizational capacity to perform its service delivery functions.

Organization: Working with MOH organizational entities at the ZS, provincial and national levels, we will identify, prioritize, and detail areas needing the most attention to build their organizational capacity.

Systems: USAID IHP will build the capacity of institutions and communities to use existing systems, including the human resources management and supply chain systems. Through intra-sector and inter-level collaboration, we will identify and address implementation challenges to ensure positive outcomes.

At each level, the USAID IHP team will develop the skills to enable and support capacity development at the next level down, in a cascading approach to building capacity. Processes at each level must work in tandem if USAID IHP is to successfully strengthen the health systems of DRC's MOH.

7.6 PRIVATE SECTOR

The private sector health care providers in the DRC have been recognized as a large but relatively unmapped and un-integrated component of the health system. Especially with the MOH focus on decentralization, the potential contributions of the private sector have received inadequate attention, and constraints that prevent these providers from meeting the needs of the populations they serve have been mostly ignored. Insecurity and political uncertainty have also led to a reluctance to invest in private health care institutions and services, and regulation of any such operations has also suffered. There exist few venues for private sector providers or potential private sector partners (such as the mining companies) to participate in local or national-level decision-making and contributions around health care, as decentralization has not caught up to create these kinds of forums and avenues for PPPs.[7] The private sector players registered in the DHIS2 include pharmacies, clinics, private hospitals, individual doctors, and religious organizations delivering services. Many more are not registered and not formally identified throughout the country.

The role of USAID IHP lies mainly within the DPS and ZS functions of the MOH and our community-based programming with local private sector stakeholders must be active. While it is not specifically a

[7] Brunner, Bettina; Combet Virginie; Callahan Sean; Holtz, Jeanna; Mnagone, Emily; Barnes, Jeff; Clarence, Cathy; Assi, Auguste; Gober, Stephanie. 2018. Le Role du Secteur Prive dans l"Amelioration de la Performance du Systeme de Sante en Republique Démocratique du Congo, Bethesda, Maryland, USA, Abt Associates Inc.

role of the program to develop private sector programs in the health sector, these key players and providers of health care should not be ignored. USAID IHP will engage with our DPS and ZS partners to include representation of the private sector in community-based and sectoral-based forums and discussions. The private sector is different from civil society, although some overlapping concerns may be shared, such as access to medicines and scarce resources and lack of infrastructure. Other topics are specific to the private sector, such as regulation, certification, development of PPPs, and the overall business environment for enterprises in the DRC. Now is an opportune time to help the DPS and ZS organizations to strategize about including the private sector. Increased attention to the private sector's ability to make unique contributions to service availability was evident during the September 25, 2018 conference, *Présentation des Résultats de l'Evaluation du Secteur Privé de la Santé en RDC.* Guidance and attention at the national level needs to flow down to the DPS and ZS levels to understand their respective roles in recognizing, stimulating, leveraging and regulatingthe private sector. While not a major element of USAID IHP, we will collaborate with donors such as the World Bank, International Finance Corporation (IFC), and the Bill and Melinda Gates Foundation to understand existing or new programmatic thrusts, and work with the DPS, ZS and community-based organizations to include the private sector in planning activities.

7.7 CLIMATE RISK MITIGATION, ENVIRONMENTAL MITIGATION & MONITORING

USAID IHP will use strategies to mitigate discharge of greenhouse gases and other contributors to climate change. These will include maximizing the sourcing of local materials; using energy-efficient materials and methods when rehabilitating facilities; establishing supply chains that maximize capture of waste materials; using drones for targeted medical deliveries; investing in bandwidth to expand virtual communication; and exploring alternative modes of transportation. The program's Environmental Mitigation and Monitoring Plan (EMMP) and Climate Risk Management Plan (CRMP) will identify required measures and activities to comply with these environmental regulations. These plans were submitted separately and are available upon request.

ANNEX A: USAID IHP ACTIVITIES FROM JANUARY 31, 2018-PRESENT, 2018

ACTIVITY	SCHEDULE	COMMENTS
Administrative Activities		
Notice of Award to Abt Associates	January 31, 2018	
Start-up Activities began	Feb 1, 2018-Feb 15, 2018	Began to draft mobilization plan, started actions needed to hire identified staff, began internal processes to open local bank accounts, update country-level registration, began actions so start-up team could obtain visas and mobilize to DRC, etc.
Stop Work Order communicated to Abt	February 15, 2018	All start-up activities ceased.
Stop Work Order was lifted by USAID	May 26, 2018	Start-up activities recommenced.
Start-up activities re-started	May 26, 2018-Present	Key personnel hired, others identified I proposal hired. Job advertisements placed and recruiting/screening/ interviewing begun. Temporary office local identified. Search for long-term office activated. Bank accounts set up, registration updated, etc.
Post Award Kick-off Meeting with USAID	June 5, 2018	USAID provided introductions and guidance for start-up and contract to Abt management.
Subcontracts with partners begun	June 5, 2018, ongoing	Negotiations, finalization of scopes of work (SOWs), budgets, instructions regarding contract, start-up information conveyed.
Mobilization of Regional Directors to their posts	Week of Aug 13, 2018 various	Eastern Congo (Janvier Barhobogayana), Armand Utshudi (Kasai), Ndalambo Kanku (Katanga)
Inventory reception of IHP Plus furniture, equipment, vehicles	June 15-Aug 25, 2018	Began preparations and discussions with Pathfinder/MSH team and USAID for turnover of equipment in the provinces and Kinshasa, including implementing storage and security plans for inventory until offices established. Reception completed.
Procurement, preparation and shipment of information technology (IT) equipment (computers, servers, monitors, docking stations, etc.)	June 5-ongoing, 2018	Procurement based on original procurement plan completed, imaging and configuration of ~160 computers and services completed, shipment awaiting tax exemption documentation from GDRC via USAID (received 9/28/18)
Prepare templates per Branding Implementation Plan	August 2018	Using the approved BIP, USAID IHP Communications prepared templates for documents such as reports, PowerPoint presentations, memos, and letters, to be used by the USAID IHP.
Technical Activities		
Planning and conduct of Work Plan workshop	Planning: June 5-Jul 26, Workshop: Jul 23- 27	Held with subcontractors, staff, USAID representatives, program orientation and team building.

Meetings held with USAID to prepare for meetings with MOH	July 30, 2018-Ongoing	Met with Acting Mission Director, Ambassador, USAID Technical staff, eventually the new Mission Director in larger introductory meeting at USAID
Initial meeting with Minister of Ministry of Health	August 13, 2018	Introductory meeting with Minister regarding USAID IHP objectives and overview, to be followed afterwards by meetings with other Ministry departments and counterparts
Meetings with Ministry personnel	August 14, 2018-Ongoing	Introductory meetings, followed by work plan specific meetings
Meetings with USAID project partners	Beginning Jul 16, 2018 ongoing	IGA, Breakthrough Action, GHSC-TA, MSH, MEASURE Evaluation, USAID Food for Peace (FFP), USAID Strengthening Value Chains Activity (SVC)
Met with MSH on technical turnover of IHPplus actions and suggested "seminar" with Ministry to take place on lessons learned; helped to construct the seminar	July 31, 2018 and subsequent meetings	Technical transition meeting at which USAID IHP COP Peter Eerens suggested a "lessons learned" meeting with Ministry regarding IHPplus learnings. Planning occurred subsequently to organize and prepare presentations with MOH and MSH personnel.
Held seminar with MOH and MSH to extract lessons learned from IHPplus	August 23, 2018	Held with MOH, MSH, USAID, and USAID IHP
Preparation, research, interviews, workshops for the Conflict Sensitivity Report	Various dates, August 2018	IRC conducted workshops in Eastern Congo, Kasai and Katanga during August to prepare and research the report
Preparation, research, interviews, workshop for the Gender Analysis and Gender Implementation Strategy	Various dates, Aug-Sept 2018	Pathfinder conducted research and meetings to prepare and research the report
BlueSquare work on Monitoring and Evaluation System, with Research, Monitoring, and Evaluation (RM&E) team	Aug-Sept-Oct 2018	Construction of database for data collection and reporting of USAID IHP Monitoring and Evaluation (M&E) data.
Courtesy visits of USAID IHP Regional Directors in their locations with MOH DPS officials	Aug/Sept 2018	Meetings following Ministry approval to meet with DPSs
Deliverables		
Mobilization Plan	July 2, 2018	Submitted and approved.
Branding Implementation Plan (BIP)	July 24, 2018	Submitted and approved.
Express Safety and Security Contingency Plan	July 30, 2018	Submitted and acknowledged.
Quarterly Report, FY18, Q3 (Apr-Jun '18), including French and English summaries	August 9, 2018	Submitted and approved.
Annual Work Plan, Year 1	August 31, 2018 (orig) Oct 19, 2018 (revision)	Submitted, USAID feedback received, revision to be submitted.
Climate Risk Mitigation Plan (CRMP)	September 6, 2018 (orig) Sept 28, 2018 (revision)	Submitted, USAID feedback received, revised version submitted
Environment Mitigation and Monitoring Plan (EMMP)	September 6, 2018 (orig) Sept 28, 2018 (revision)	Submitted, USAID feedback received, revised version submitted
Activity Monitoring and Evaluation Plan (AMEP)	September 6, 2018 (Orig) Oct 19, 2018 (revision)	Submitted, USAID feedback received, revision to be submitted

Program Management Plan (PMP)	September 6, 2018 (Orig) Oct 19, 2018 (revision)	Submitted, USAID feedback received 10/2/18, revision to be submitted
Conflict Sensitivity Analysis and Gender Implementation Strategy	September 6, 2018 (orig) Oct 11, 2018 (revision)	Submitted, USAID feedback received (9/26), revision to be submitted.
Updated Procurement Plan	September 6, 2018 (Orig) Oct 19, 2018 (revision)	Submitted, will update with revised budget to be submitted with revised work plan on Oct 19, to reflect any changes in personnel
Capacity Development Approach	Due Oct 5, 2018	This report was part of Abt's proposed deliverable list for fee performance achievement.
Gender Analysis and Gender Implementation Strategy	Revised due date: Nov 2, 2018	In preparation.
Monitoring and Evaluation System	Due Oct 19, 2018	In preparation. Presentation of draft system to USAID being requested for Oct 18, 2018