

DEMOCRATIC REPUBLIC OF THE CONGO
MINISTRY OF HEALTH
GENERAL SECRETARIAT



Scale-up Strategy for Essential Medicines for Child Survival

Diarrheal Disease, Malaria and Pneumonia

2012-2015

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ACRONYMS

ADDO – Accredited Drug Dispensing Outlet
AMM or AIM - Autorisation de mise sur la marché or Authorization to Introduce on the Market
HZCO – Health Zone Central Office (Bureau central de zone, BCZ)
GMP – Good Manufacturing Practices
RDD – Regional Drug Depot (Centrale de distribution régionale, CDR)
CMO – Chief Medical Officer
PDC – Provincial Drug Committee (Comité provincial de médicament)
HC – Health Center (Centre de santé)
GPRSP - Growth and Poverty Reduction Strategy Paper
DPM – Drugs, Pharmacy and Medicinal Plants Directorate (Direction de la Pharmacie, Médicaments et Plantes médicinales)
PHD – Provincial Health Division (Division Provinciale de Santé)
DMT – District Management Team (Equipe cadre district, ECD)
PMT – Provincial Management Team (Equipe cadre province, ECP)
WASH – Water and Hygiene and Sanitation (Eau, Hygiène, Assainissement)
ZMT – Health Zone Management Team (Equipe cadre de la zone de santé, ECZ)
EMI – Essential Medicines Initiatives
FEDECAME – Federation of Essential Drug Procurement Agencies/Depots (Federation des Centraux d'Approvisionnement en médicaments essentiels)
IPF – DRC Industry Promotion Funds (FPI, Fond de promotion de l'industrie en DRC)
GDRC – Government of the Democratic Republic of the Congo
GRH – General Referral Hospital (Hôpital Général de Référence, HGR)
NIC – Nurse In-charge (Infirmier Titulaire, IT)
LQAS - Lot Quality Assurance Sampling
MICS 2010 - Multiple Indicator Cluster Survey 2010
PMI – Provincial Medical Inspector (Médecin Inspecteur Provincial, MIP)
MoH – Ministry of Health
MDG – Millennium Development Goal
WHO – World Health Organization
iCCM - Integrated Community Case Management (PCCIC, Prise en charge communautaire intégrée des cas)
IMCI – Integrated Management of Childhood Illness (PCIME, Prise en charge intégré des maladies de l'enfant)
c-IMCI – Community Integrated Management of Childhood Illness (PCIME-C, Prise en charge intégré des maladies de l'enfant – communautaire)
HZHCMDP - Health Zone Health Care Development Master Plans (PDZS, Plans de développement sanitaires des zones de santé)
FP –Focal Point
NP – National Program
NEMSP – National Essential Medicines Supply Program (PNAME, Programme national d'approvisionnement en médicaments essentiels)
NHCDMP – National Health Care Development Master Plan (PNDS, Plan national de développement sanitaire)
NARICP – National Acute Respiratory Infections Control Program (PNIRA, Programme national de lutte contre les infections respiratoires aiguës)
NDDCP – National Diarrheal Disease Control Program (PNLMD, Programme national de lutte contre les maladies diarrhéiques)
NMCP – National Malaria Control Program (PNLP, Programme national de lutte contre le paludisme)
PHCDMP – Provincial Health Care Development Master Plans (PPDS, Plans provinciaux de développement sanitaire)
DRC – Democratic Republic of the Congo
CHCS agent – Community Health Care Site agent (Relais de Site)
CHCS – Community Health Care Sites (Site des Soins Communautaires)
NEMSS – National Essential Medicines Supply System (SNAME, Système national d'approvisionnement en médicaments essentiels)
HMIS – Health Management Information System (Système national d'information sanitaire, SNIS)
SPS – Support to Strengthen Pharmaceutical Management Systems
ORS – Oral Rehydration Salts
SRSS – Stratégie de renforcement du système de santé or Strategy to Strengthen the Health System
RDT – Rapid Diagnostic Test
HZ – Health Zone (Zone de Santé, ZS)

1. EXECUTIVE SUMMARY

Following an important decline in stability and relative prosperity, and “complete free-fall during the decade of conflict that accompanied the collapse of the Zairean state^{1, pg.4},” the Democratic Republic of the Congo (DRC) is now establishing strategies and policies to strengthen its health system. Despite its heightened efforts, however, the DRC still has one of the highest child mortality rates in the world, far from the target set under Millennium Development Goal (MDG) 4. To achieve the target of 66/1,000 as estimated in the Secretary-General’s presentation entitled “*Evolution de l’état de santé de la population congolaise*” (“Health Status of the Congolese Population”) during the 2010 Annual Review of the Ministry of Health², an additional 58% reduction is necessary. A reduction of this magnitude demands a significant effort in the second most populous country of sub-Saharan Africa³, where “70%-80% of the population has little or no access to health care^{1, pg.5},” and lives below the poverty line¹.

The new global Essential Medicines Initiative (EMI) is set on achieving universal coverage in ORS/zinc for diarrhea, dispersible Amoxicillin for pneumonia and ACTs for malaria for children under 5 to help countries like the DRC achieve MDG 4 by 2015. This approach is appropriate in the DRC, where rational treatment coverage is limited. Only 1 in 10 children with a fever receive ACTs in accordance with national guidelines^{4,5}, only one-third of children under 5 with diarrhea receive ORS⁵, and less than half of those with pneumonia receive antibiotic therapy⁶. In the DRC, limited access to quality, primary health care services is the major obstacle to universal ORS/zinc, dispersible Amoxicillin/Cotrimoxazole and ACT coverage because modern health care services are beyond the reach of an estimated 70% of patients³.

The strategic approach described below synergistically integrates the public, private and community sectors, with the main focus on access. It endeavors to capitalize on the strengths of each of these sectors to achieve national coverage. For feasibility and practical reasons, the health district is the chosen geographic unit to ensure that at least each of the 65 health districts has a model health zone to lead project-related health intervention in the district and among private organizations (conventional private, faith-based or non-governmental organizations) and thus help fill district-level gaps. In the five poorest provinces with the remotest populations and highest mortality rates, the public and private sectors are complemented by Community Health Care Sites (CHCS).

The strategy proposes 4 objectives and 7 interventions likely to contribute to the overall goal.

- Objective 1: Social and policy environment enabled
This objective is supported by Intervention 1: “Integrate the three national programs (NMCP, NARICP and NDDCP) under the leadership of Directorate 5 (to be confirmed)”¹.
- Objective 2: Access to and availability of quality, primary health care services increased.
This objective is supported by three interventions, namely: “Identify/establish *model* HZs in the public sector,” “Establish an accreditation program to regulate the private sector,” and “Extend community health care sites coverage under the authority of the Health Centers.”
- Objective 3: Access to and availability of quality treatment increased.
This objective is supported by two interventions: “Promote the drug distribution system and local manufacturing of EMI drugs” and “De-medicalize ORS/zinc and ensure its universal coverage.”
- Objective 4: Demand for quality, primary health care services and positive behaviors increased.
This objective is supported by intervention 7: “Comprehensive Behavior Change Communications Campaign.”

The Government of the Democratic Republic of the Congo (GDRC) and its technical and financial partners prioritize rational treatment coverage for the control of diarrhea, malaria and pneumonia. They support the global universal coverage goal in an effort to help the country achieve MDG 4 by 2015. They view this strategy as a vital step in attaining universal coverage.

¹ The national programs will be integrated based on the MoH internal reorganization currently in progress. If the MoH decides to incorporate these programs into one or several other directorates, the strategy will comply with the MoH decision. In this document, the title of Intervention 1 includes the words *to be confirmed* to highlight this situation.

2. ANALYSIS AND STRATEGIC BACKGROUND INFORMATION

2.1 Access to Essential Medicines

Following an important decline in stability and relative prosperity, and “complete free-fall during the decade of conflict that accompanied the collapse of the Zairean state,”^{1, pg.4} the Democratic Republic of the Congo (DRC) is now establishing strategies and policies to strengthen its health system. The President of the Republic, in his 2006 future outlook on social progress in the DRC over the coming five years, identified health as one of *Cinq Chantiers* or “Five Building Blocks.” The *Stratégie de Renforcement du Système de Santé* (SRSS or *Strategy to Strengthen the Health System* (SSHS))³ and its *Plan National de Développement Sanitaire* (PNDS or *Health Care Development Master Plan* (HCDMP))⁴ focus on providing quality primary care to the entire population. The SRSS is centered on « la reconnaissance de la Zone de Santé (ZS) comme seule unité opérationnelle de planification et de mise en œuvre des soins de santé primaires (SSP) dans le respect des principes d’intégration, continuité, globalité des soins centrés sur l’homme^{4, pg.10} »² and focused on the availability of a basic service package at the Health Centers (HC) and a full package at the General Referral Hospitals (GRHs). All of the statistics^{2,5,6} point to a diminishing child mortality rate since 1990. The most recent Multiple Indicator Cluster Survey 2010 (MICS 2010) data reveal a child mortality rate of 158/1,000⁶. Despite its heightened efforts, the DRC still has one of the highest child mortality rates in the world, far from the Millennium Development Goal (MDG) 4 target. To achieve the target of 66/1,000, as estimated in the Secretary-General’s presentation entitled *Evolution de l’état de santé de la population congolaise* (“Health Status of the Congolese Population”) during the *2010 Annual Review of the Ministry of Health*², a further 58% reduction is necessary.

A reduction of this magnitude demands a significant effort in the second most populous country of sub-Saharan Africa³, where “70%-80% of the population has little or no access to health care^{1, pg.5}” and lives below the poverty line¹. The DRC is one of the ten countries that account for more than half (60%) of the deaths worldwide from malaria, pneumonia and diarrheal disease among children under 5. The WHO World Health Statistics 2010 document breaks down the causes of death among children under 5 in the DRC as follows: 17% malaria, 19% diarrheal diseases and 20% pneumonia⁷.

Table 1: Situation Overview

General Information			
Child mortality rate 1990	199/1,000 ²		
1992-1997	172/1,000 ⁵		
1997-2002	165/1,000 ⁵		
Child mortality rate 2007	165/1,000 ² 148/1,000 ⁵		
Child mortality rate 2010 Annual Review	158/1,000 ^{2,6}		
Child mortality rate 2015 Target	66/1,000 ²	Source: 2010 Annual Review ²	
	Diarrhea	Malaria	Pneumonia
Incidence (episodes/year)	6 ⁸	6-10 ⁴	4-6 informant
Prevalence	16% ⁵	31% ⁵	15% ⁵
Mortality	19% ⁷	17% ⁷	20% ⁷
Care Seeking			
% of cases where treatment was sought from a health facility or health care provider	33% ⁵	45% (fever symptom) ⁵	42% ⁵
Coverage– Treatment			

² Translation: “recognition of the Health Zone (HZ) as the only operational planning and implementation unit for primary health care (PHC) focused on integrated, coordinated and comprehensive patient-centered care.”

Rational treatment	31% (ORS) ⁵ n/a (zinc) ⁵	10% (ASAQ on same or following day) ^{4,5}	42% Antibiotic therapy ⁶
First-line therapy	n/a (Antibiotics) ⁵	16% (Quinine per os) ⁵ 10% (within 24 hrs) ⁵	n/a (Amoxicillin)
Other treatment, even if contrary to national guidelines	27.7% (tablet/syrup) ⁵ 0.8% (IV) ⁵ 24.4% (home remedies, other) ⁵	3.1% (SP/Fansidar) ⁵ 6.2% (Chloroquine) ⁵ 1.3% or less (other) ⁵	n/a

The global Essential Medicines Initiative (EMI) proposes the goal of universal coverage for ORS/zinc to treat diarrhea, dispersible Amoxicillin to treat pneumonia and ACTs to treat malaria in children under five in order to help countries like the DRC achieve MDG 4 by 2015. This approach is appropriate in the DRC, where Table 1 above shows the limited extent of rational treatment coverage. Only one-third of children under age 5 with diarrhea receive ORS⁵, only 1 in 10 children with a fever receive ACTs in accordance with national guidelines^{4,5}, and less than half of those with pneumonia receive antibiotic therapy⁶. For diarrhea, zinc is not systematically used for treatment, which shows that this important treatment component is given insufficient priority.

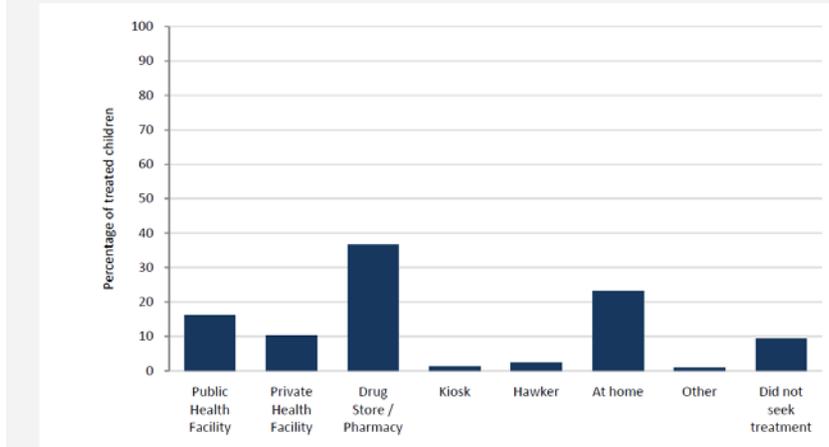
Care-seeking and using the health services required to ensure rational use of these medicines is a problem in the DRC due to health care service access and quality challenges. As the SRSS explains:

« Le taux moyen de l'utilisation des services de santé selon le rapport de l'Etat Santé et Pauvreté en RDC (Banque Mondiale, 2005) est d'environ 0,15 (0,07 – 0,42) consultations par habitant et par an qui correspond à moins d'une consultation par personne tous les 6 ans. Deux tiers des patients en RDC ne recourent pas au système de santé formel pour obtenir les soins, soit parce que les services ne sont pas disponibles ou sont de mauvaise qualité quand ils existent, soit parce qu'ils n'ont pas de moyens (financiers) pour y accéder. Selon une étude réalisée par l'Ecole de Santé Publique de l'Université de Kinshasa en 2003, parmi les membres de familles qui sont tombés malades, 30% sont allés dans un centre de santé public ou confessionnel, 40% ont pratiqué l'automédication, 21% n'ont reçu aucun traitement et 9% ont consulté un guérisseur traditionnel. Ceci correspond à environ 70% des malades qui n'ont pas accès aux services de santé modernes³. »³

Users cover up to 70% of the health system's operating costs, which makes it extremely expensive to seek care³. The "fee-for-service" method instituted by care providers makes health care all the more expensive³. The following charts from the ACTWatch *Household Survey The Democratic Republic of the Congo, 2010 Survey Report*⁹ show where and why primary care is sought for children with fevers. The charts illustrate a heavy reliance on pharmacies/the private sector and home remedies for reasons based chiefly on cost and distance.

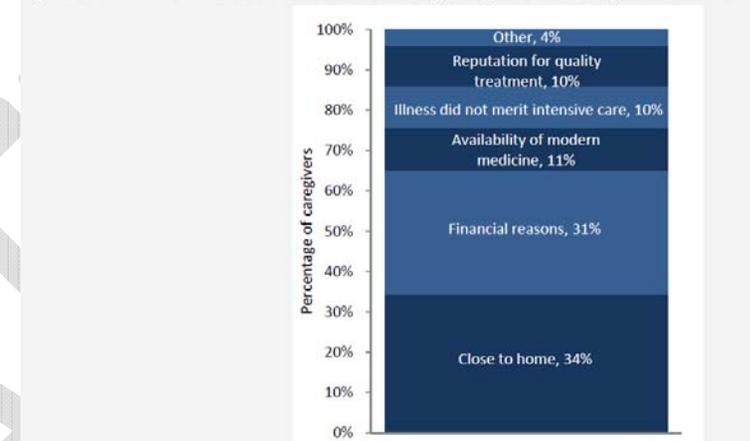
³ Translation: "According to the DRC Country Health and Poverty Status Report (World Bank, 2005), the average rate of health care service use is approximately 0.15 (0.07 – 0.42) consultations per resident per year, which amounts to less than one consultation per person every six years. Two-thirds of patients in the DRC do not turn to the official health system to obtain care either because services are not available or fall below standards, or because they lack the means (financial) to obtain them. According to a 2003 study by the Kinshasa University School of Public Health, 30% of family members who became ill visited a public or denominational Health Center, 40% self-medicated, 21% received no treatment and 9% consulted a traditional healer. This means that approximately 70% of the sick have no access to modern health care services."

Figure 7. First source of treatment for children with fever



Source: ACTWatch Group⁹

Figure 8. Reason for first treatment source among caregivers who sought treatment



Source: ACTWatch Group⁹

Limited access to quality primary health care services is the most significant barrier to universal ORS/zinc, dispersible Amoxicillin/Cotrimoxazole and ACT coverage. At the same time, an excessive number of gaps in the public sector and at the community level prevent a traditional public and/or community sector approach. The answer to the problem of widespread access to quality services and treatment may reside in an approach that incorporates the private sector. Attention to the availability of treatment, but also the cost of treatment, could also encourage people to seek care, given that affordability is a significant barrier to the use of health services in the DRC.

2.1.1 Treatment Sources – Public and Private

Public Sector

Traditionally, « Jusqu'en 1990, le système de santé de la RDC était réputé pour son réseau de cliniques ainsi que la qualité de médecins et des soins de santé primaires délivrés ^{10, pg. 1.} »⁴ The health zone (HZ) formed the foundation of the health system pyramid, constituting the operational basis for health care organization and planning in DRC. In the 1990s, however, the public health system started to decline. The crisis brought with it the deterioration of HZ infrastructures and coordination. Today, instead of a Health Zone Management Team (ZMT) that coordinates and strives to integrate efforts within the HZ, and supervise/manage care providers, the ZMT is sometimes left-out and “forgotten” during vertical, sectorial programming ³. Furthermore, many GRHs and HCs operate as separate entities, more like competitors than a coherent referral system³. Service quality problems in the HCs cause many patients to turn to the GRHs for primary care, which takes work away from the HCs and shifts it to the GRHs.³ As a result, the GRHs are spending too much time on primary health care and not enough time on referred cases, while the HCs have too few patients to cover their costs and have therefore starting seeking other “solutions,” such as the “fee-for-service” method, in order to survive ³. This situation is one of the major reasons why « environ 70% des malades...n'ont pas accès aux services de santé modernes ^{3, pg. 18.} »⁵

Previously, the Government of the DRC (GDRC) instituted a series of policies and procedures to strengthen the health system and IMCI (Integrated Management of Childhood Illness), decentralize the health system, and establish national programs to address the specific needs of various diseases. The outcome was the establishment of 13 directorates and 52 national programs, as well as a three-tiered health system. The system includes « un niveau central, un niveau intermédiaire qui compte 11 Inspections Provinciales de la Santé et 65 Districts Sanitaires et un niveau périphériques qui comprend théoriquement 515 Zones de Santé (ZS) avec 393 HGR et 8.266 CS ^{11, pg.4.} »⁶ With so many directorates, national programs and levels, work is needed to improve integration, collaboration and effectiveness. Accordingly, the SRSS proposes an eventual integration and reduction in the number of directorates from 13 to 7, and a moratorium on the creation of new national programs ³.

Extensive efforts have also been made to meet the challenges of access, early care-seeking and service quality at the HZ level, as proposed in the SRSS. Approximately 246 of the 515 health zones (48%) are currently supported by partner interventions (estimated at 80 under PROSANI (Integrated Health Project), 83 under the WB (World Bank), 67 under the EU and 16 under CIDA (Canadian International Development Agency)). Over half of the HZs derive no benefit from these intensive interventions, however. In response, the Ministry of Health, with support from UNICEF and the WHO, ensures that all 515 HZ engage in certain public health activities that have a strong impact on reducing mortality, namely, routine vaccinations, de-worming, vitamin A supplementation, and the distribution and use of treated mosquito nets in accordance with the National Malaria Control Program (NMCP) strategic plan. In terms of community-level responses, the DRC has a long history of extensive intervention under c-IMCI (community Integrated Management of Childhood Illness)/NDDCP (National Diarrheal Disease Control Program) leadership and coordination. Several partners have helped establish and extend a community approach in the DRC using Community Health Care Sites, especially BASICS/MCHIP, IRC, Project AXxes, CIDA/PSI, UNICEF, WHO and now, PROSANI/MSH. Despite the implementation of an estimated 1,228 Community Health Care Sites (CHCS), almost one-half are not operational. The stakeholders estimate a need for 10 sites on average per HZ, which amounts to 5,150 Community Health Care Sites and a gap of 3,922 to 4,536 sites, depending on the number of non-operational sites.

⁴ Translation: “Until 1990, the DRC health system was known for its clinic network and the quality of its doctors and primary health care.”

⁵ Translation: “approximately 70% of the sick have no access to modern health care services.”

⁶ Translation: “a central level, an intermediary level with 11 Provincial Health Inspectorates and 65 Health Districts, and a peripheral level that in theory includes 515 health zones (HZ) with 393 GRHs and 8,266 HCs.”

Private Sector

In the DRC, the private sector is strong and extends into every corner of the country, despite its enormous size. As shown in the charts above, ACTWatch estimates that pharmacies comprise 40% and private health facilities 10% of the treatment sources for children with fever ⁹. Historically, the DRC health sector has boasted important public-private partnerships. « Le système de santé en RDC est une bonne illustration du concept de collaboration entre les institutions publiques et privées pour la gestion des services de santé. Dans un contexte marqué par une forte présence des réseaux religieux, le GRDC choisit de tirer parti des infrastructures et des services existants et gérés par des acteurs non-gouvernementaux plutôt que d'entrer en concurrence avec eux ^{12, pg.1.} »⁷ The Health Zone (HZ) concept was the product of this partnership in 1975 and, as a result, the traditional private sector, faith-based organizations and non-governmental organizations (NGOs) currently manage a significant number of health centers and hospitals ¹². More recently, the private sector has also experienced an increase in the number of Instituts des Techniques Médicales (Medical Technical Institutions) that are training care providers in numbers that exceed the demand in preferred geographic areas. « Le nombre des diplômés des ITM est passé d'une moyenne annuelle d'environ 1.500 entre 2001 et 2005 à environ 3.000 et plus entre 2007 et 2009 ^{3, pg. 15.} »⁸

Public Supply System

The Système National d'approvisionnement en médicaments essentiels (Essential Medicines Supply System (NEMSS)) also plays an important role in universal coverage and care-seeking, given that stock-outs are closely associated with perceived service quality.

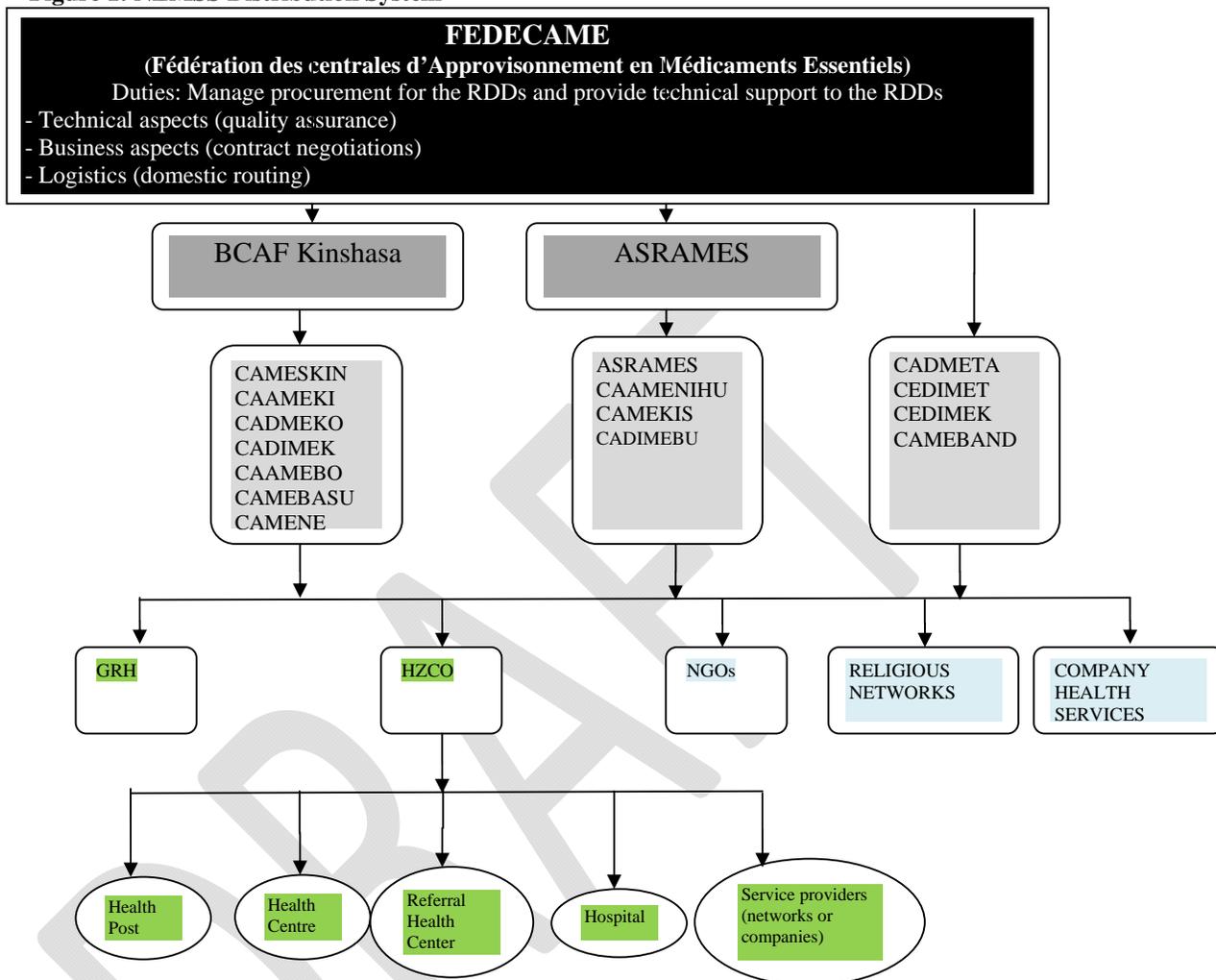
The DRC created the Programme National d'Approvisionnement en Médicaments Essentiels (National Essential Medicines Supply Program (NEMSP)) to manage the NEMSS through its supply chain (see Figure 1). At the NEMSS national level, the Fédération des Centrales d'Approvisionnement en Médicaments Essentiels (FEDECAME or Federation of Essential Drugs Procurement Centers/Depots) centralizes pharmaceutical supplies to achieve economies of scale. FEDECAME comprises representatives of the Centrale de Distribution Régionale (Regional Drug Depots (RDD)) ¹³, which are independent, not-for-profit regional distribution depots. Currently, 15 RDDs are in operation out of the 26 needed nationally. In theory, each RDD serves 10 to 20 HZ. In Figure 1 below, the two grey areas represent the RDDs. The General Referral Hospitals (GRH) and the HZCO (Health Zone Central Offices) obtain supplies directly from the regional distribution centers (RDDs) ¹³. HZ health facilities obtain supplies from the Health Zone Central Offices ¹³. Relais de Site (community health care site agents) at the Community Health Care Sites obtain their integrated community case management (ICCM) supplies from the Health Centers.

Since August 2001, a pilot drug system has been operating in each province. The role of this body, known as the Provincial Drug Committee (PDC), is to keep abreast of stock system developments and recommend when and what supplies must be procured to avoid stock-outs, duplicate orders and waste.

⁷ Translation: "The health system in the DRC is a good example of collaboration between public and private institutions in managing health care services. Given the strong presence of religious networks, the GDRC has chosen to take advantage of existing infrastructures and services managed by non-governmental stakeholders, rather than compete with them."

⁸ Translation: "The number of MTI graduates climbed from an annual average of approximately 1,500 between 2001 and 2005 to approximately 3,000 or more between 2007 and 2009."

Figure 1: NEMSS Distribution System¹³



BCAF = FEDECAME Procurement Coordination Office

One major strategic challenge the NEMSS faces in managing the supply chain is the cost of drugs. According to the document *Prise en Charge Communautaire Intégrée des Maladies de l'Enfant : Documentation des Meilleures Pratiques et des Goulots d'Etranglement à la mise en œuvre du programme en RDC* (« Integrated Community Case Management of Childhood Illness: documentation on implementation best practices and bottlenecks in the DRC »)¹¹, « La population participe aux coûts des médicaments mais, le contexte de pauvreté de la population ne permet pas au Ministère de la Santé et à ses partenaires d'envisager un recouvrement total des coûts pour assurer un renouvellement autonome des stocks et une pérennisation de l'approvisionnement en médicaments ^{11, pg.39}. »⁹

2.1.2 Access to Diarrhea Treatment

The DRC established a National Diarrheal Disease Control Program (NDDCP) with the following objectives: « (a) Promouvoir les mesures préventives de lutte contre les maladies diarrhéiques ; (b) Prendre en charge correctement les cas de diarrhée dans les formations sanitaires et dans la communauté ; (c) Réduire la contamination au sein de la communauté et particulièrement dans les

⁹ Translation: "The population contributes to the cost of drugs, but poverty prevents the Ministry of Health and its partners from contemplating full cost recovery as a means of ensuring independent stock replenishment and a sustainable drug supply."

zones à risque d'épidémies ; (d) Mettre en place un système de surveillance épidémiologique dans la communauté ^{8, pg. 9.} »¹⁰ The NDDCP also ensures technical coordination of the c-IMCI component. In accordance with standards, « la communauté fait la promotion des mesures préventives, prend en charge les cas simples, notifie et réfère les cas avec signes de danger aux Centres de Santé ^{8, pg.15.} »¹¹ Therefore, the community has the authority to administer first-line therapy, i.e., ORS/zinc. ORS/zinc has not yet been de-medicalized in the DRC, however, which has generated extensive regulations governing its distribution and limited the effectiveness of its distribution at the community level.

The NDDCP receives no government funding to accomplish its objectives apart from the resources to cover salaries and benefits. The WHO recommends that 60% of pediatric care providers be up-to-date in their IMCI training, yet less than half of the country's HZ (215 or 220 out of 515) have IMCI-trained care providers. As a result, care providers and Community Health Care Site agents are very often unaware of treatment standards and consequently fail to offer zinc as part of the recommended diarrhea treatment. To strengthen the NDDCP's work and recognition for rational treatment, UNICEF has identified five key public health messages, including the treatment of diarrhea with ORS/zinc.

In the private sector, the cost of an ORS sachet is approximately \$0.16 and the cost of a blister pack of 10 zinc tablets is about \$0.50/treatment. A supply problem exists in all sectors not because of stock-outs specifically, but due to a mismatch between supply and demand. Section 2.2 offers further explanation.

2.1.3 Access to Malaria Treatment

With significant financial support from donors, the National Malaria Control Program (NMCP) is well organized in the DRC, equipped with provincial NMCP services in all provinces¹⁴ and holds regular Task Force meetings at the national and provincial levels ¹⁴. Under NMCP standards, artesunate + amodiaquine (ASAQ) has been the first-line therapy since 2005. According to the NMCP's 2007-2011 strategic plan, one of the targets is « 80% des patients atteints du paludisme bénéficient d'un diagnostic et d'un traitement conformes aux directives nationales à tous les échelons de la pyramide sanitaire ¹⁴. »¹² GFATM (Global Fund to Fight AIDS, Tuberculosis and Malaria) complements the NMCP's efforts by providing a minimum treatment package to 119 HZs. At the community level, the Community Health Care Site agents also support the NMCP's efforts with the distribution of ASAQ. A new policy requires a positive laboratory diagnosis before the administration of malaria treatment, but major stock-outs in rapid diagnostic test (RDT) kits have been an obstacle to enforcing the policy.

According to the ACTWatch report entitled *Household Survey The Democratic Republic of the Congo, 2010 Survey Report*, "Antimalarials were most commonly sourced from drug stores and pharmacies, according to caregiver responses. Over half of all antimalarials (51%) were from this source. By comparison, 27% of all antimalarials were sourced from public health facilities.... However, this pattern is reversed for ACTs: 42% of ACTs were sourced from public health facilities and 36% from drug stores and pharmacies ^{9, pg. 9.}" The ACTWatch report indicates that the average cost of a course of quinine across all sales outlets amounts to \$0.40, and of ACTs, \$0.57 ⁹. The high cost of ACTs is an additional challenge to their rational use.

2.1.4 Access to Pneumonia Treatment

In DRC, Cotrimoxazole is currently the first-line treatment recommended by the National Acute Respiratory Infection Control Program (NARICP). Programs focused on HIV/AIDS are advocating to change the policy guidelines in order to restrict Cotrimoxazole to opportunistic disease treatment and name Amoxicillin for pneumonia treatment. The Ministry of Health (MoH) is currently analyzing Cotrimoxazole resistance to determine the best course of action.

¹⁰ Translation: "(a) Promote preventive diarrheal disease control measures; (b) Ensure the effective management of diarrheal cases through health training and in the community; (c) Reduce contamination in the community, especially in epidemic risk zones; (d) Establish a community-based epidemic monitoring system."

¹¹ Translation: "the community promotes prevention, manages simple cases, identifies and refers cases exhibiting danger signs to the Health Centers."

¹² Translation: "80% of malaria patients are diagnosed and treated in accordance with national guidelines at every level of the health care pyramid."

Although pneumonia does not receive a great deal of attention in the DRC, the country stands apart from others given the existence of its National Acute Respiratory Infection Control Program (NARICP) specifically addressing pneumonia control since 2003. Like the NDDCP, however, the NARICP does not have a government budget to achieve its objectives, apart from the funds to cover salaries and benefits. While the National Diarrheal Disease Control Program (NDDCP) focuses more on community-level IMCI, the NARICP focuses more on clinical IMCI. Without budget funds, however, only one-half of clinical care providers have received IMCI training. Many care providers are unaware of changes in standards and policies related to pneumonia treatment, which fosters irrational treatment, as explained in Section 2.2. To support the work of the NARICP, the Community Health Care Site agents distribute Cotrimoxazole.

Amoxicillin moves faster in the private sector, but costs more than Cotrimoxazole. Cotrimoxazole currently costs about \$1 in the private sector. Antibiotic therapy is often prescribed by care providers, and combined with 3-4 other medicines in a single prescription³, which leaves caregivers with the impression that pneumonia treatment is expensive. According to a 2007 survey on drug costs, « un ménage doit consacrer la moitié du salaire journalier moyen pour soigner une épisode d'IRA^{11, pg. 39}. »¹³

2.2 Evaluation of the Major Barriers Preventing Access to Treatment

Section 2.1 described the situation in the DRC in terms of access and use of child survival treatments. Several major barriers were mentioned, including the limited availability of quality services and reluctant care-seeking. Table 2 outlines key cross-cutting and disease-specific barriers to access and rational use of appropriate treatments related to patient demand and/or the public and private sector.

Table 2	Patient	Public sector supply/provision (incl. community-level)	Private sector supply/provision
Cross-disease	<ul style="list-style-type: none"> (a) Inadequate access to care (distance, cost and quality). (b) Poor knowledge of other diseases because of an emphasis on malaria. (c) The belief that antibiotics and IVs are more effective. (d) Self-referral to the GRH or private sector instead of Health Centers. (e) Use of traditional medicine and prayer groups. (f) Self-medication and use of private pharmaceutical outlets. (g) Misperception of the disease (coughing not considered an illness). 	<ul style="list-style-type: none"> (a) Weak links between the health system and the community: between GRHs and HCs. Between health facilities in the HZs and the ZMT. Between the HZs and Community Health Care Sites. (b) Stock-outs and lack of information: non-systematic use of the Health Management Information System and poor integration of community information and supply needs. (c) Poor service quality: insufficient training, motivation, materials, dissemination of policy, etc. (d) National Essential Medicines Supply System (NEMSS) not yet formalized or systematically used. (e) Limited quality assurance and drug regulation. (f) Vertical and sectorial child survival approach (52 national programs and 13 directorates). (g) Inadequate and outdated IMCI training. (h) Inadequate government funding (2.5% 2008). (i) Inadequate coverage in Community Health Care Sites. (j) Lack of community-level coordination. (k) Attrition of Community Health Care 	<ul style="list-style-type: none"> (a) Difficult for local manufacturers to obtain "GMP" status from the WHO. (b) Without GMP status from the WHO, technical and financial partners will not order medicines from local manufacturers. (c) International procurement of medicines raises costs. (d) Limited credit/lending support for private local manufacturers. (e) Uneven geographic distribution of pharmacists. (f) Need for greater integration of effort across the public and private sectors. (g) Excess of unregulated, questionable medicines (40%). (h) Abundance of private/informal health facilities outside the health system. (i) Non-inclusion of the

¹³ Translation: "a household spends half of an average day's wages to treat an episode of acute respiratory infection."

		<p>Site agents: need to formalize and motivate.</p> <p>(l) Need to clarify community health policy.</p> <p>(m) GRHs and HCs obtain supplies more often from private drug outlets than Regional Drug Depots.</p>	private pharmaceutical sector in the NEMSS.
Diarrhea	<p>(a) Limited focus on prevention (Water, Hygiene and Sanitation, WASH).</p> <p>(b) Limited point-of-source water treatment.</p> <p>(c) Limited knowledge of zinc use.</p> <p>(d) Limited care-seeking (33%).⁵</p> <p>(e) Low confidence in the effectiveness of ORS/zinc.</p> <p>(f) Practice of limiting liquid and food intake for children with diarrhea.</p>	<p>(a) Insufficient dissemination of the new ORS/zinc policy resulted in expiration of the zinc stock followed by stock-outs. *The non-existence of a logistics management system for the ORS/zinc combination *Insufficient care provider capacity-building.</p> <p>(b) Reduced prescription of ORS (without zinc) related to the zinc stock-out.</p> <p>(c) National Diarrheal Disease Control Program (NDDCP) receives insufficient resources to accomplish its mission.</p> <p>(d) Limited access to potable water and insufficient focus on hygiene and sanitation.</p>	<p>(a) ORS and zinc stock-outs and stock expiration.</p> <p>(b) Perceived low return on investment, especially for zinc.</p> <p>(c) Separate packaging of ORS and zinc.</p>
Malaria	<p>(a) Aversion to Amodiaquine because of the side effects.</p> <p>(b) Malaria self-diagnosis and excessive symptomatic diagnoses.</p> <p>(c) Limited care-seeking (45%).⁵</p> <p>(d) Irrational use of treatment: Quinine 16% vs. ACT 10%.⁵</p> <p>(e) Need to focus on behavior change: Use of LLIN among children under 5 (19%) less than availability (28%).⁵</p>	<p>(a) New policy requires a positive laboratory diagnosis prior to administering malaria treatment. Lack of sufficient diagnostic materials (RDT or lab) and training.</p> <p>(b) Limited care provider knowledge of how to respond to a negative RDT.</p> <p>(c) Due to limited dissemination of the new policy, many care providers and caregivers continue to make their diagnosis on the assumption that fever = malaria.</p> <p>(d) Irrational prescription of medicines because of ACT stock-outs.</p> <p>(e) Missed opportunity to integrate prevention and treatment of other diseases into GFATM zones.</p>	<p>(a) Difficult for local manufacturers to obtain GMP certificate from the WHO and therefore impossible to produce ACTs for funding bodies willing to buy locally.</p> <p>(b) Cost of unsubsidized ACT very expensive for the general public.</p> <p>(c) ASAQ (first line) in low demand compared to other medicines. Patients do not like Amodiaquine.</p>
Pneumonia	<p>(a) Limited knowledge of pneumonia: rule of thumb that fever = malaria.</p> <p>(b) Excessive use of antibiotics and self-medication.</p> <p>(c) Limited care-seeking (42%).⁵</p> <p>(d) Insufficient knowledge of prevention methods.</p> <p>(e) Insufficient focus on prevention and identifying cost-effective solutions.</p>	<p>(a) Poor quality service: irrational and excessive prescription of antibiotics.</p> <p>(b) Misdiagnosis of pneumonia as malaria (fever = malaria, systematic failure to count respiration).</p> <p>(c) Frequent Cotrimoxazole stock-outs among Community Health Care Site agents. "Forgotten" by HCs during restocking.</p> <p>(d) Overuse of Cotrimoxazole</p> <p>(e) Poor dissemination of acute respiratory infection policies, standards and guidelines.</p> <p>(f) NARICP receives insufficient resources to accomplish its mission.</p>	<p>(a) Not familiar with pneumonia control policy and guidelines.</p>

2.2.1 Barriers for All Diseases

2.2.1.1 Patients, Caregivers and Care Providers

In terms of expected results, care providers and the caregivers of children believe that antibiotics and injections are more effective than other treatments. A review of what is included in medical

prescriptions for sick patients further supports this finding. A 2006 study by the MoH revealed « une moyenne de 4 médicaments par ordonnance, 62,2% d'ordonnances avec au moins un antibiotique et 32,6% avec une injection ^{3, pg.25}. »¹⁴ As underscored in the SRSS, « La prescription et la dispensation sans normes claires définies contribuent à augmenter l'utilisation irrationnelle des médicaments ^{3, pg. 24}. »¹⁵

In the public sector, there is insufficient initial and refresher training and coaching/supervision in terms of IMCI and the importance of using medicines rationally. The WHO recommends that 60% of pediatric care providers have up-to-date IMCI training, yet only one-half of the country's HZs (215 or 220 out of 515) has IMCI-trained care providers. Many of the people who received the training have already left the public sector and entered the private sector, and the percentage is therefore probably lower than estimated. Furthermore, dissemination of new policies and standards, as well as information, education and communication material to promote good behavior is also insufficient.

2.2.1.2 Supply

Creation of the NEMSS is an important step toward organizing and regulating drug distribution in the DRC, where an estimated 40% of drugs circulating in Kinshasa are below quality standards. Unfortunately, the NEMSS is not yet entirely operational or systematically used. The SRSS shows that the supply chain is still very complex with parallel systems involving 19 supply agencies and 99 distribution systems ³. Eighty-five percent of partners use their own supply agencies³ and do not directly finance FEDECAME's procurement activities, which deprives the NEMSS of the funds it needs to strengthen its capacity. Only 15 RDDs are in operation (covering 337 HZ), although 26 RDDs are needed (to cover 515 HZs). Despite regulations, the HCs very often procure their supplies from the private sector because of the lower cost and faster delivery time compared to the RDDs. However, in spite of the use of alternative and unofficial supply chains, stock-outs remain a problem. A 2009 study cited in the SRSS showed that only 15% of the GRHs had all of the recommended trace drugs at the time of the survey ³. Stock-outs are also a serious problem at the community level. Community Health Care Site agents procure their supplies from the HCs. But the HCs often forget to take account of community needs when placing their orders, resulting in community stock-outs.

Partners create parallel data gathering systems, as well, leaving each HC to complete approximately 40 reports each month ³. These parallel systems weaken the Health Management Information System (HMIS) and its ability to monitor stocks. Furthermore, despite efforts to create software for a community level HMIS, community and Community Health Care Site data are not usually incorporated into the HMIS.

Drug regulation and control issues are also a major barrier to supply quality. An excessive number of unregulated and therefore questionable medicines circulate on the market. According to the in-depth interviews, a study currently in progress shows that more than 3,000 types of medicines are available on the market, yet the Drugs, Pharmacy and Medicinal Plants Directorate (DPM) has issued Authorization for Introduction on the Market (AMM) for only 400. Drug regulation and control is, therefore, an issue.

2.2.2 Diarrhea Barriers

2.2.2.1 Patients, caregivers and care providers

In terms of diarrheal disease, care providers and the caregivers of children under five do not yet realize the important treatment role of zinc. Dissemination of the new policy, guidelines and standards is still insufficient in the HZs, especially in rural areas, despite the circular issued in 2009 by the Secretary-General on the use of zinc and its management at the RDDs. For guardians and care providers, insufficient zinc use is also related to a preference for the so-called "curative" antibiotics and IVs mentioned above, and to the fact that ORS and zinc are packaged separately, creating an additional hurdle in terms of proper use. According to the 2007 Health Survey, of the persons who sought care for children under five, 27.7% received syrup/tablet treatment compared

¹⁴ Translation: "an average of 4 medicines per prescription, with 62.2% of prescriptions including at least one antibiotic and 32.6% one injection."

¹⁵ Translation: "Prescribing and dispensing drugs without clearly defined standards increases the irrational use of medicines."

to 31% who received ORS ⁵. All of this is not to say, however, that ORS is not used. In fact, ORS is used quite frequently, but not necessarily in a rational manner. Dosage recommendations are not monitored, even at the GRHs.

Another behavior-related problem that affects care is the decision to limit the amount of liquids and food given to children with diarrhea. According to the 2007 DHS, 15.6% of caregivers gave slightly less liquid, 12.8% much less and 6.4%, no liquid ⁵. Limiting food intake is another problem. The same source reported that 33% limited food intake somewhat, 11% significantly and 11% entirely.

2.2.2.2 Supply

The major diarrhea treatment supply challenge is the insufficient demand for zinc. In 2009, UNICEF supplied a large stock of zinc and distributed it directly to the provinces in cooperation with the NDDCP and other partners. Much of the zinc stock sent to the HZs ultimately expired. After a major pharmacist conference in 2009, pharmacy wholesalers, such as Unique Pharma, purchased a great deal of zinc to support the policy change. The stock expired, and pharmacies now order less zinc because they see no return on their investment. Procurement relies on orders by the RDDs, estimated on the basis of use. Since zinc is underused, the need for it is underestimated, the return on investment is low, and insufficient supplies are procured to meet needs.

Sometimes RDDs have zinc in stock, but health facilities do not. Health facilities do not order zinc from the RDDs for several reasons: (i) they cooperate more often with private depots than with the RDDs, which they consider expensive, (ii) they rarely prescribe zinc to patients, either because they are unaware of the change in policy or unconvinced of the importance of zinc, (iii) they are not accustomed to dealing with the RDDs. Despite efforts to promote zinc, many care providers are awaiting formal training on the use of zinc with ORS, leaving existing stocks to expire.

2.2.3 Malaria Barriers

2.2.3.1 Patients, Caregivers and Care Providers

The irrational use of antimalarial treatment is linked to several factors, including the diagnostic approach to malaria used by many care providers, ACT stock-outs, a preference for Amodiaquine-free medicines, the affordability of quinine, and lack of knowledge about ACTs as an antimalarial. In terms of diagnosis, the long-held rule of thumb was that fever = malaria, and care providers therefore often associate fever with malaria based on symptoms rather than a confirmed diagnosis. Limited dissemination of the new policy requiring treatment based on a positive laboratory diagnosis means that most care providers continue to use the fever=malaria approach to diagnosis and therefore continue to over-diagnose and treat malaria rather than consider other illnesses involving a fever. At the same time, the new policy in itself constitutes a barrier to rational diagnosis because the required RDT and ACT stock is not available. Concerning caregivers, the ACTWatch report reveals that, “90% of children’s guardians say they know where to obtain antimalarials for children under age 5. However, when they were asked to name the medicines used to treat malaria, only 6% spontaneously named ACT.” ^{9, pg. 12}

In terms of preferences for certain medications, quinine is the most frequently used treatment, despite treatment guidelines. The ACTWatch *Household Survey the Democratic Republic of the Congo, 2010 Survey Report* reveals a 27% rate of quinine use compared to 4.5% for ACTs ⁹, and the 2007 DHS reports quinine use at 16% ⁵. The preference for quinine is partly due to ACT stock-outs and the greater affordability of quinine. The ACTWatch report lists the average cost of a course of quinine across all sales outlets at \$0.40 compared to \$0.57 for ACTs ⁹.

2.2.3.2 Supply

As mentioned above, ACT stock-outs in the HZs are an important problem that influences people to turn to quinine instead ^{4, pg. 25}. One of the problems involved in ACTs supply in the DRC is that it is difficult for local manufacturers to obtain “GMP” status from the WHO, making it impossible to manufacture ACTs for donors willing to buy locally. Therefore, donors have to procure their supplies outside the country, which consequently raises prices, slows delivery times and opens the door to prolonged stock-outs.

The presence of Amodiaquine in ASAQ is another barrier to its use. Patients prefer ALu because it has fewer side effects. ASAQ moves slower than ACT medicines, like ALu, and so the private sector purchases less ASAQ as a first-line treatment.

2.2.4 Pneumonia Barriers

2.2.4.1 *Patients, Caregivers and Care Providers*

Barriers to rational pneumonia treatment are intimately linked to those of malaria. Often, care providers and caregivers identify fever as a sign of malaria rather than pneumonia. As a result, pneumonia often escapes early detection and is identified only after it reaches a more critical stage. The importance of malaria is overestimated, resulting in high demand for antimalarial responses. The outcome is a deficit in demand for responses to pneumonia.

Insufficient dissemination of policy guidelines, regulations and key messages among care providers and caregivers is another important barrier that undermines efforts to promote the identification of warning signs, early treatment and rational treatment. More extensive development and dissemination of messages promoting pneumonia prevention is needed.

2.2.4.2 *Supply*

Ensuring a sufficient supply of Cotrimoxazole is not a problem. Amoxicillin sells even more easily and quickly, however, with a potential higher return on investment for pharmacies. A change in policy that gives priority to Amoxicillin could make supplies even more readily available. There are supply issues at the community level, however, where the HCs often “forget” to take account of community needs in their orders, which results in shortages and stock-outs.

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2.3 Current Efforts by the Ministry of Health (MoH) and Partners, and Identification of Priority Domains

Developed in 2006 and revised in 2010, the SRSS proposes an approach to strengthen the health system³. It constitutes the health sector's response to the *Document de la Stratégie de Croissance et de Réduction de la Pauvreté (DSCRCP), juillet 2006*¹⁵ (*Growth and Poverty Reduction Strategy Paper (GPRSP), July 2006*) and complies with its recommendations. The National Health Care Development Master Plan (NHCDMP) entitled *Plan National de Développement Sanitaire PNDS 2011-2015, March 2010*⁴ elaborates on the SRSS implementation plan by including Plans Provinciaux de Développement Sanitaire (PPDS) or Provincial Health Care Development Master Plans (PHCDMP), which in turn contain Plans de Développement Sanitaires des Zones de Santé (PDSZ) or Health Zone Health Care Development Master Plans (HZHCDMP). The NHCDMP follows a bottom-up implementation plan within the health care pyramid. The National Diarrheal Disease Control Program (NDDCP) mission includes managing integration of IMCI and integrated Community Case Management (ICCM) through Community Health Care Sites and their agents^{8,16}. The policies mentioned here play a key part in child survival initiatives. Their objectives, strategies and targets are presented in Table 3.

As a complement to the GDRC's efforts, a few key projects are currently applying SRSS strategies at the operational level (HZ), including the "Integrated Health Project" (PROSANI) funded by USAID and implemented by MSH (in 80 HZs), the « Projet d'Appui à la Réhabilitation du Secteur Santé » ("Health Sector Rehabilitation Support Project") funded by the World Bank (in 83 HZs), the activities of the European Union (in 67 HZs), the project funded by CIDA and implemented by ASF/PSI (in 16 HZ), etc. Combined, these projects cover at least 246 of the 515 HZs, or 48%. The governments of Belgium (CTB), Germany (GiZ) and Italy are also involved in complementary interventions. UNICEF has created 60 HCs and 40 GRHs through HZ interventions amounting to \$7 million. The SPS project (Support to Strengthen Pharmaceutical Management Systems) funded by USAID and executed by MSH provides technical support for the creation of a National Essential Medicines Supply System (NEMSS) through the development of policy, supply chains, distribution systems and regulations. The project also reinforces the drug regulation capacity of the Drugs, Pharmacy and Medicinal Plants Directorate (DPM). It supported the creation of an Authorization to Introduce on the Market (AMM) Committee to study files and samples of 160 drugs each quarter. At present, over 600 drugs have obtained their AMM through this committee (approximately 60%). The MSH/SPS also introduced software for an Internet-based AMM system. The WHO, CTB and GiZ are also working to strengthen the drug supply system and the HMIS. UNICEF is working on development of the 5 key messages and the supply of essential medicines. GFATM is one of the largest funding bodies, with a focus on HIV/AIDS, malaria and tuberculosis at all levels of the system. With the 8th Round, the GFATM is also focusing on pharmacovigilance. This list is not exhaustive, but gives a general idea of key projects in the DRC.

New initiatives in the field of child survival and essential medicines should comply with GDRC policies and strategies developed in the 2010 SRSS and the 2011-2015 NHCDMP. They should also align with other projects being implemented for greater synergy.

Table 3: Key GDRC Policies and Strategies Supporting Child Survival

	Document de la Stratégie de Croissance et de Réduction de la Pauvreté (DSCR), Juillet 2006 / Growth and Poverty Reduction Strategy Paper (GPRSP), July 2006 ¹⁵	Stratégie de Renforcement du Système de Santé 2010 (SRSS), 2010 / 2010 Strategy to Strengthen the Health System (SSHS), 2010 ³	Plan National de Développement Sanitaire PNDS 2011-2015, Mars 2010 / National Health Care Development Master Plan (PNDS) 2011-2015, March 2010 ⁴	Déclaration de Politique Nationale de Lutte Contre les Maladies Diarrhéiques (Juillet 2008), et PNLMD Normes et Directives National (Août 2008) / Policy Statement of the National Diarrheal Disease Control Program (NDDCP, July 2008), and NDDCP Standards and National Guidelines (August 2008) ^{8,16}
Goals, Objectives and Important Targets	<p><i>Translated from French to English</i> Pillar 3 Health Objective: Ensure that the entire population receives quality primary health care, especially vulnerable groups, and control the major pandemics such as HIV/AIDS, malaria, tuberculosis, onchocerciasis, human African trypanosomiasis, etc.</p> <p>Pillar 5 Objective: (i) community participation in planning and decision-making; (ii) promotion, creation and legal recognition of community development organizations; (iii) action capacity-building for community development organizations: planning, management, monitoring and project assessment and (iv) capacity-building to support grassroots community initiatives, with special attention given to initiatives by women and youth.</p> <p>5 Pillars: PILLAR 1. Promote good governance and consolidate peace by reinforcing institutions. PILLAR 2. Improve macroeconomic stability and growth. PILLAR 3. Improve access to social services and reduce vulnerability.</p>	<p><i>Translated from French to English</i> Goal: To improve the supply, quality and use of health services by the entire Congolese population. Health sector's contribution to poverty reduction.</p> <p>System-related problems and possible causes 2.3.1 Problems related to the lingering nature of the crisis. 2.3.2 Lack of a proper frame of reference for defining zone services– General Referral Hospital, Zone Management Team 2.3.3 Perverse effects of health funding. 2.3.4 Misunderstanding of community participation– strong surge in community agents. 2.3.5 Human resource problems – burgeoning staff, increase in health facilities in the HZs. 2.3.6 Lack of Ministry leadership in the sector –decrease in government health budget, disjointed health services in the HZ, a dozen or so micro plans in the HZ, approximately 40 HMIS reports. 2.3.7 Drug sector problems. The NEMSS is still confronting problems that prevent its normal operation: (i) the coexistence of several parallel systems complicates the supply chain, (ii) lack of</p>	<p><i>Translated from French to English</i> Goal: The goal of the NHCDMP is to enhance the wellbeing of the Congolese population by 2015. General objective: To help improve the health of the population within a poverty reduction framework. Sectorial objective: To ensure that the entire population has access to quality primary health care, especially vulnerable groups, in order to control major epidemics and non-communicable diseases.</p> <p>Four strategic orientations: (i) develop the Health Zones, (ii) support Health Zone development, (iii) strengthen leadership and governance in the sector, and (iv) reinforce inter-sectorial collaboration.</p> <p>Regarding the second strategic orientation (support for Health Zone development), five support strategies will be implemented: (i) human resource development in the health field, (ii) support for the drug sector, (ii) a reform of health financing, (iv) construction and/or renovation of health infrastructures and equipment and the introduction of new technologies, (v) improved health</p>	<p><i>Translated from French to English</i> Goal: The goal of the policy is to help improve the general state of health of the population, especially children under five, by controlling diarrheal diseases.</p> <p>Objectives: 1. Promote preventive action in controlling diarrheal diseases. 2. Properly manage diarrhea cases at health facilities and in the community. 3. Reduce contamination in the community, especially in epidemic risk zones. 4. Establish an epidemic surveillance system in the community.</p> <p>Strategies: 1) Promote preventive measures in all of the country's health zones. 2) Proper case management at health facilities and in the community. * Community Health Care Site agents/Relays (1 per neighborhood/village for communication/promotion, 1 iCCM agent per 20 members or more, 2 site agents per site)</p>

<p>PILLAR 4. Control HIV/AIDS. PILLAR 5. Support community dynamics.</p> <p>338. Renovation and creation of new health facilities (hospitals, health centers, pharmacies, etc.) within reach, human resource development through basic training and on-the-job capacity building, improved working conditions for health care staff, the supply of basic pharmaceutical products, and hospital, health center and university clinic equipment.</p> <p>381. The Government (...) is firmly committed to promoting such community dynamics and has included it as one of the key pillars of the Growth and Poverty Reduction Strategy (GPRSP) for implementation at every level.</p> <p>Strategies (i) Health zone development; (ii) institutional reorganization and support at the intermediary and central levels and (iii) medicine supply and specific inputs.</p> <p>Deliverables: - Reduction in child mortality from 104‰ in 2007 to 89‰ in 2008 compared to 111‰ in 2006. - The maternal mortality rate should also diminish by 2008 to 944 per 100,000 live births from 1,275 in 2006. - The number of assisted births should increase to 75.2% from 61.6% in 2006. Vaccination coverage is apparently improving at 40% in 2008 compared to 29.6% in 2006.</p>	<p>GDRC ownership of the NEMSS, (iii) NEMSS's sales are insufficient, and (iv) the pharmaceutical sector is not adequately regulated.</p> <p>2.3.8 Health service and care delivery – Disjointed health services in the HZs, decentralized intervention, lucrative, unregulated private sector.</p> <p>6 Strategic orientations 3.2.1 Revitalization of the health zone and correction of relevant distortions - The health zone as a planning and implementation unit. - Begin with health zones that exhibit the greatest development potential. Begin with health centers with the greatest development potential. 3.2.1.1 Integrated leadership development within the health zones. 3.2.1.2 Rationalization of health facility operations. 3.2.1.3 Improvement of health coverage in the health zones. 3.2.1.4 Improvement in the quality of care. 3.2.1.5 Community participation. 3.2.2 Reinforcement of governance and leadership 3.2.2.1 Health sector reform and decentralization. 3.2.2.2 Reform of the Health Management Information System. 3.2.2.3 Research on the health system. 3.2.2.4 Health system direction. 3.2.2.5 Improved management of health facilities and other health organizations. 3.2.3 Development of human resources in the health sector by improving skills and motivation considering that human resources are the very foundation of all interventions, including health interventions.</p>	<p>information management.</p> <p>Principles: (i) Recognition of the Health Zone as the only primary health care operational planning and implementation unit meant to uphold the principles of integrated, comprehensive, patient-centered care. (iii) Effective decentralization in order to redistribute authority, responsibility and resources [Provincial Health Divisions (PHD)] (vi) Harmonization and alignment of assistance to ensure that the government health budget and fluctuations in international aid are aligned to NHCDMP priorities and use coordinated management mechanisms established by the Government (...)</p> <p>Targets: <u>Target 1:</u> Reduce the maternal mortality rate from 549 (DHS 2007) per 100,000 to 300 by 2015. <u>Target 2:</u> Help reduce the child mortality rate from 92 to 40 deaths per 1,000 live births by 2015. <u>Part of Target 3</u> "maîtriser le paludisme et d'autres grande maladies et commencer à inverser la tendance actuelle (pg. 68)." "Taux de prévalence du paludisme et taux de mortalité lie à cette maladie (pg. 68)." (Translation: "Control malaria and other major diseases and begin reversing the current trend (pg. 68)." "Prevalence rate of malaria and the mortality rate associated with it (pg. 68).") <u>Target 7:</u> Increase the percentage of the population that has access to quality primary health care by 30% by 2015. <u>Target 7 (repetition):</u> Raise the percentage of full vaccinations among children from 31% to 55% by 2015.</p>	<p>3) ORT (oral rehydration therapy) promotion at health facilities and in the community throughout the DRC. 4) Establishment of an epidemic surveillance system and effective fast community response.</p> <p>Support strategies: 1) Planning of diarrheal disease control activities. 2) Reinforcement of technical and managerial capacities. 3) Supply of essential medicines and supplies. 4) Resource mobilization and management. 5) Partnership. 6) Research. 7) Lobbying. 8) Social marketing. 9) Behavior change communications. 10) Monitoring and evaluation.</p> <p>"la communauté fait la promotion des mesures préventives, prend en charge les cas simples, notifie et réfère les cas avec signes de danger aux Centres de Santé ^{8,pg. 15}." (Translation: "The community promotes preventive measures, manages simple cases, notifies and refers cases showing signs of danger to the Health Centers.")</p> <p>Community IMCI under the technical coordination of the NDDCP. The community component of IMCI includes: - promotion of key practices and - management of simple cases by Relais des Sites (Community Health Care Site agents).¹⁶</p>
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	<p>3.2.4 Drug sector reform. - GDRC ownership of the NEMSS. - Reinforcement of government leadership - Improvements in local production and in the use of medicines by health facilities</p> <p>3.2.5 Health funding reform.</p> <p>3.2.6 Reinforcement of intra- and inter-sectorial partnership.</p> <p>Budget: 9,364,328,171 CDF (2011-2015)</p>	<p>Target 8: Increase the percentage of children < 5 who sleep under treated mosquito nets and children receiving proper treatment for malaria/fever from 6% to 40% and 25% to 80%, respectively.</p> <p>Deliverables: 284. Increase the use of curative services by 25%. The rate of health service use varies from 0.15 to 0.25 contacts per resident per year. The rate of curative service use should therefore climb to approximately 0.40 to 0.50 contacts per resident per year.</p> <p><u>II. Strategy 2.</u> R1. Medicine availability is ensured in all HZs according to their category. R.2 80% of the population can afford essential and generic medicines by 2015. R.3 80% of essential and generic medicines and supplies in circulation are of good quality by 2015</p> <p><u>II. Strategy 3.</u> R1. The health budget increases each year to attain 15% of the National Budget by 2015, with improvements in the implementation rate and in the effectiveness of government funds allocated to health. R2. Fragmentation of international aid channeled to health gradually diminishes in keeping with the Kinshasa agenda.</p>	
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Table 4 below combines the barriers described above in Section 2.2 and the current and ongoing efforts by the GoT and partners to respond to these barriers. Elements in yellow highlight the domains of insufficient or lacking current efforts where this project will prioritize its efforts.

Table 4	Patient		Public sector supply/provision (incl. community-level)		Private sector supply/provision	
	Barriers	Current efforts	Barriers	Current efforts	Barriers	Current efforts
Cross-disease	<p>(a) Inadequate access to care (distance, cost and quality).</p> <p>(b) Poor knowledge of other diseases because of an emphasis on malaria.</p> <p>(c) The belief that antibiotics and IVs are more effective.</p> <p>(d) Self-referral to the GRH or private sector instead of Health Centers.</p> <p>(e) Use of traditional medicine and prayer groups.</p> <p>(f) Self-medication and use of private pharmaceutical outlets.</p> <p>(g) Misperception of the disease (coughing not</p>	<p>(a) Creation of 1,228 Community Health Care Sites since 2006 staffed by 2,310 site agents well-trained in disease management.</p> <p>Extension of Health Care Sites to 108 additional HZ (GFATM Round 10). A serious gap persists.</p> <p>- Health funding initiatives (ex., mutual health care insurance, HC user incentives, subscriber fees and community funds).</p> <p>(b) Limited action. New policy to address this issue.</p> <p>(c) Limited action.</p> <p>(d) Health funding initiatives (ex. mutual health care insurance, HC user incentives, subscriber fees and community funds).</p> <p>(e-f) Limited action.</p> <p>(g) Promotion of key practices and 5 key messages.</p>	<p>(a) Weak links between the health system and the community: between GRHs and HCs. Between health facilities in the HZs and the ZMT. Between the HZs and Community Health Care Sites (care providers do not believe in the Health Care Sites and “forget” to restock supplies for the Health Care Workers).</p> <p>(b) Stock-outs and lack of information: non-systematic use of the Health Management Information System and poor integration of information and community stock</p>	<p>(a-c)(g) Projects like USAID/PROSANI (80 HZ), World Bank (83 HZ), GFATM, BAD, EU (67 HZ), UNICEF (with HCs and GRHs). GAVI initiative.</p> <p>- Six model HZ identified.</p> <p>- SRSS developed. 50% of HZ not yet affected.</p> <p>-IMCI training tools revised.</p> <p>Serious gaps.</p> <p>(b) GIZ working with Directorate 5 on HMIS.</p> <p>(d,m) Establishment of national divisions and programs within the GDRC to focus on NEMSS.</p> <p>-Increased use of NEMSS by technical and financial</p>	<p>(a) Difficult for local manufacturers to obtain “GMP” status from the WHO.</p> <p>(b) Without GMP status from the WHO, technical and financial partners will not order medicines from local manufacturers.</p> <p>(c) International procurement of medicines raises costs.</p> <p>(d) Limited credit/lending support for private local manufacturers.</p> <p>(e) Uneven geographic distribution of pharmacists.</p> <p>(f) Need for greater integration of effort across the public and</p>	<p>(a-c). Need to focus on local manufacturing (ZENUFA, New Cesamex, Phatkin, and Pharmakina) and distribution.</p> <p>(d) Limited action. ZENUFA receives support from the Industry Promotion Fund.</p> <p>(e) Ministry of Health is making an effort to assign pharmacists to the HZs.</p> <p>(f) -Pilot experiment to include IMCI training for staff at private pharmaceutical facilities.</p> <p>- Introduction of RDTs in private sector.</p> <p>- Ministry of Health issues service</p>

	considered an illness).		<p>needs.</p> <p>(c) Poor service quality: insufficient training, motivation, materials, dissemination of policy, etc.</p> <p>(d) National Essential Medicines Supply System (NEMSS) not yet formalized or systematically used.</p> <p>(e) Limited drug quality assurance and regulation.</p> <p>(f) Vertical and sectorial child survival approach (52 national programs and 13 directorates).</p> <p>(g) Inadequate and outdated IMCI training.</p> <p>(h) Inadequate government funding (2.5% 2008).</p> <p>(i) Inadequate coverage in Community Health Care Sites.</p> <p>(j) Lack of community-level coordination.</p> <p>(k) Attrition of Community Health Care Site agents: need</p>	<p>partners.</p> <p>- Provincial Drug Committee (PDC) provides direction at provincial level.</p> <p>- Existence of harmonized NEMSS procedural manuals since November 2011.</p> <p>-WHO project to strengthen the NEMSS.</p> <p>(e) SSPMS project, GFATM projects.</p> <p>-CTB, Regulatory Authority Reinforcement Project.</p> <p>(f) Development of SRSS recommending 7 directorates.</p> <p>- Projects like PROSANI, WB and EU comprise integrated approaches in the HZs.</p> <p>(i) Creation of 1,228 Community Health Care Sites since 2006 staffed by 2,310 Health Care Workers well trained in disease management.</p> <p>Extension of Community Health</p>	<p>private sectors.</p> <p>(g) Excess of unregulated and questionable medicines (40%).</p> <p>(h) Abundance of private/informal health facilities outside the health system.</p> <p>(i) Non-inclusion of the private pharmaceutical sector in the NEMSS.</p>	<p>contracts to partners to manage health services.</p> <p>-Study on local long-term LLIN production.</p> <p>(g)</p> <p>- SSPMS project.</p> <p>-CTB, Regulatory Authority Reinforcement Project.</p> <p>(h)</p> <p>- HZ-level projects (integration and holistic approach): PROSANI (80 HZs), World Bank (83 HZs), EU (67 HZs), UNICEF facility development.</p> <p>- Six model HZs identified</p> <p>- SRSS developed. 50% of HZs not yet reached.</p> <p>(j) Limited action.</p>
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			to formalize and motivate. (l) Need to clarify community health policy. (m) GRHs and HCs obtain supplies more often from private drug outlets than from regional drug depots.	Care Sites to 108 additional HZs (GFATM Round 10). Serious gaps. (h)(j-l) . Limited action. (k,l)		
Diarrhea	<p>(a) Limited focus on prevention (Water, Hygiene and Sanitation, WASH).</p> <p>(b) Limited point-of-source water treatment.</p> <p>(c) Limited knowledge of zinc use.</p> <p>(d) Limited care-seeking (33%).⁵</p> <p>(e) Low confidence in the effectiveness of ORS/zinc.</p> <p>(f) Practice of limiting liquid and food intake for children with diarrhea.</p>	<p>(a-b). -ASF/PSI project with Proctor & Gamble and UNICEF/UNDP (Social Marketing of PuR and Aquatab products). - USAID AIDSTAR project by ASF/PSI. -Projects like PROSANI, WB AND EU. -UNICEF/VEA, Oxfam/ boreholes; water projects; focus on the 5 key messages, WASH and zinc supply.</p> <p>(c-f). -Projects like PROSANI, WB AND EU. - UNICEF focus on the 5 key messages, WASH, Zinc supply. - Creation of 716 Community Health Care Sites since 2006. - CIDA integrated community case management project. - Community Health Care Site agents distribute ORS zinc. - Health funding initiatives,</p>	<p>(a) Insufficient dissemination of the new ORS/zinc policy resulted in expiration of the zinc stock followed by stock-outs.</p> <p>- The non-existence of a logistics management system for the ORS/ zinc combination.</p> <p>- Insufficient reinforcement of care provider capacity.</p> <p>(b) Reduced prescription of ORS (without zinc) related to zinc stock-outs.</p> <p>(c) National diarrheal disease control program (NDDCP) receives insufficient resources to accomplish its mission.</p>	<p>(a-b). - USAID social marketing projects in the DRC (ASF) and PROSANI, WB AND EU are integrated approaches in the HZs. 50% HZs are not reached. - UNICEF focus on the 5 key messages, WASH and zinc supply. - Existence of NDDCP training plans</p> <p>(c) Limited action, but alignment and integration of interventions</p> <p>(d) - OXFAM - USAID project AIDSTAR by ASF/PSI. - ASF/PSI project with Proctor & Gamble, UNICEF/UNDP (SM</p>	<p>(a) ORS and zinc stock-outs and stock expiration.</p> <p>(b) Perceived low return on investment, especially for zinc.</p> <p>(c) Separate packaging of ORS and zinc.</p>	<p>(a) - Projects like MSH, WB and EU constitute approaches integrated within the HZ. - UNICEF focus on the 5 key messages, WASH and zinc supply. - Social marketing in the DRC with USAID ASF.</p> <p>(b) Limited action.</p> <p>(c) Prepackaging of ORS and zinc together under the CIDA ASF/PSI project (16 HZ) and the USAID AIDSTAR project by ASF/PSI in the DRC.</p>

		<p>(ex. mutual health care insurance, HC user incentives, subscriber fees and community funds).</p> <p>- Existence of care provider training plans, dissemination of standards and guidelines for the correct management of diarrhea.</p> <p>Serious gaps</p>	<p>(d) Limited access to potable water and insufficient focus on hygiene and sanitation.</p>	<p>PuR and Aquatabs).</p> <p>- MoH 5-year project including a Water component.¹</p> <p>-UNICEF</p>		
Malaria	<p>(a) Aversion to Amodiaquine because of the side effects.</p> <p>(b) Malaria self-diagnosis and excessive symptomatic diagnoses.</p> <p>(c) Limited care-seeking (45%).⁵</p> <p>(d) Irrational use of treatment : Quinine 16% vs. ACT 10%.⁵</p> <p>(e) Need to focus on behavior change: Use of LLIN among children <5 (19%) less than availability (28%)⁵.</p>	<p>(a) Existence of the NMCP technical guide (2010 edition). ASAQ tablet packaging in co-blisters packs.</p> <p>(b-d).</p> <p>- Through the projects, caregivers recognize at least two signs of the severity of a malaria case.</p> <p>- Creation of 1,228 Community Health Care Sites since 2006 staffed by 2,310 agents well trained in the management of childhood illnesses.</p> <p>-Community involvement.</p> <p>-Pilot introduction of RDTs in the community.</p> <p>Serious gaps.</p> <p>(e) NMCP 2007-2011 strategic plan and reinforcement of prevention activities (LLIN 80%).¹⁴</p>	<p>(a) New policy requires a positive laboratory diagnosis prior to administering malaria treatment. Lack of sufficient diagnostic materials (RDT or lab) and training.</p> <p>(b) Limited care provider knowledge of how to respond to a negative RDT.</p> <p>(c) Due to limited dissemination of the new policy, many care providers and caregivers continue to make their diagnosis on the assumption that fever = malaria.</p> <p>(d) Irrational prescription of medicines because of ACT stock-outs.</p> <p>(e) Missed</p>	<p>(a-d). NMCP 2007-2011 strategic plan, management: 80% of patients with malaria are diagnosed and receive treatment in accordance with national guidelines at all levels of the health pyramid.</p> <p>- Revised IMCI clinical booklet, Kisantu edition (2011) available.</p> <p>(a-c) Insufficient action related to RDT scale-up.</p> <p>(e) Community Health Care Site package included in Round 10 GFATM Malaria</p>	<p>(a) Difficult for local manufacturers to obtain GMP certificate from the WHO and therefore impossible to produce ACTs for funding bodies willing to buy locally.</p> <p>(b) Cost of unsubsidized ACT very expensive for the general public.</p> <p>(c) ASAQ (first line) in low demand compared to other medicines. Patients do not like Amodiaquine.</p>	<p>(a) Limited action.</p> <p>(b-c) No action.</p>

			opportunity to integrate prevention and treatment of other diseases into GFATM zones.			
Pneumonia	<p>(a) Limited knowledge of pneumonia: rule of thumb that fever = malaria.</p> <p>(b) Excessive use of antibiotics and self-medication.</p> <p>(c) Limited care-seeking (42%).⁵</p> <p>(d) Insufficient knowledge of prevention methods.</p> <p>(e) Insufficient focus on prevention and identifying cost-effective solutions.</p>	<p>(a-c).</p> <ul style="list-style-type: none"> - Existence and dissemination of the new definition of malaria. - Creation of 1,228 Community Health Care Sites since 2006 staffed by 2,310 agents trained in pneumonia management. - Health funding initiatives, ex., mutual health care insurance, HC user incentives, subscriber fees and community funds. Serious gaps <p>(d-e). Promotion of key practices.</p> <ul style="list-style-type: none"> - Existence of ARI management guidelines. 	<p>(a) Poor quality service: irrational and excessive prescription of antibiotics.</p> <p>(b) Misdiagnosis of pneumonia as malaria (fever = malaria, systematic failure to take respiratory count).</p> <p>(c) Frequent Cotrimoxazole stock-outs among Community Health Care Site agents. “Forgotten” by HCs during restocking.</p> <p>(d) Overuse of Cotrimoxazole</p> <p>(e) Poor dissemination of acute respiratory infection policies, standards and guidelines.</p> <p>(f) NARICP receives insufficient resources.</p>	<p>(a-c).</p> <ul style="list-style-type: none"> - Creation of 1,228 Community Health Care Sites since 2006 staffed by 2,310 agents trained in pneumonia management. - Inclusion of clinical IMCI in 214 HZ - Existence of flow charts revised in 2011 - Health funding initiatives, ex. mutual health care insurance, HC user incentives, community involvement. Serious gaps <p>(d, e, f). Existence of ARI management standards and guidelines.</p>	<p>(a) Not familiar with pneumonia management policy and guidelines.</p>	<p>(a) Existence of policy and guidelines. Introduction of IMCI in pharmaceutical sector and private health facilities in Kinshasa (pilot phase in 2 HZ)/ MSH. Serious gaps.</p>

3. TARGETED INTERVENTION PROGRAM PROPOSAL

3.1 Vision & Objectives

In the DRC, limited access to quality primary health care services is the most serious barrier to universal coverage in ORS/zinc, dispersible Amoxicillin/Cotrimoxazole and ACT. An estimated 70% of the sick do not have access to modern health care services³. Despite many efforts made to respond to access, care-seeking and quality of service challenges in Health Zones, as proposed under the SRSS, an important gap remains. Over half of the HZs receive no intervention support and the gap in the recommended Community Health Care Site coverage is 76%-88%.

A traditional public sector and/or community sector approach on its own would most likely encounter scale-up challenges in trying to achieve universal coverage by 2015. Inclusion of the private sector (not only the traditional for-profit entities, but also faith-based organizations and NGOs) in the approach may be the answer to the scale-up problem. As mentioned earlier, the private sector is strong and has a long history of cooperation with public institutions in health service management. « Des organisations religieuses et des ONGs gèrent un nombre important de centres de santé et la moitié des hôpitaux^{12, page 1}»¹⁶ and ACTWatch estimates that pharmacies comprise 40% and private health facilities 10% of treatment sources for children with fevers⁹. The SRSS also explains that there are a large number of private/informal health structures and facilities outside the health system due to a dramatic increase in the number of Medical Technical Institutes that are training care providers in numbers that exceed demand in preferred geographic zones³. The problem with access to quality services is, therefore, not a matter of private-sector care provider availability or the level of training, but rather is a matter of including them in the regulation and supervision of the formal health system at the Health Zone level.

The strategic approach described below promotes synergistic integration across the public, private and community sectors, with the main focus on access. It endeavors to capitalize on the strengths of each of these sectors to achieve national coverage. For feasibility and practical reasons, the health district is the geographic unit chosen to ensure that at least each of the 65 health districts have one model health zone to lead project-related health intervention in the district and among private organizations (traditional private, faith-based or non-governmental organizations) to help fill district-level gaps. In the five poorest provinces with the remotest populations and highest mortality rates, the public and private sectors will be complemented by the introduction or reinforcement of Community Health Care Sites.

International experience shows that the availability of quality health care facilities alone does not mean that they will be systematically used to ensure universal coverage. At least three other key factors, as shown in Appendix 7.4, Results Framework, also play a role.

The approach takes into account each of these objectives and the range of interventions involved. The links between the interventions and the objectives are described in Section 3.2. The rationale and approach underlying each intervention are explained in Section 3.3.

The strategic approach is also based on the rationale that training alone is not a sufficient guarantee of quality service delivery. Experience shows that training alone is not enough, even though international development programs often give it special emphasis. Coaching and supervision is also necessary. A research meta-analysis by Joyce and Power (2002) showed that “training that consisted of theory and discussions coupled with demonstration, practice, and feedback resulted in only 5% of the teachers using the new skills in the classroom. When on-the-job coaching was added to training, however, large gains were seen in knowledge and teachers’ ability to demonstrate the skills, and most importantly, about 95% of the teachers used the new skills in the classroom with students^{17, pg. 446}”.

The approach proposes an overarching structure from the central level to the community level to ensure the “linkages” required for coordinated training as well as coaching/supervision and motivation. The combination of these 3 aspects will help support the behavior change sought.

The structure has four levels:

¹⁶ Translation: “Faith-based organizations and NGOs manage a large number of health care centers and half of the hospitals,”

- a) At the central and intermediary level: Integration of primary child survival health care management, and of the three national child survival programs (NDDCP, NARICP, NMCP), under the leadership of Directorate 5 (to be confirmed), to more efficiently use limited financial and human resources. The money saved will be used to identify and mobilize a national focal point with one champion/focal point per province (from 5^e bureau_DPS), per district and per model HZ (see Intervention 2). This approach will not only help to reinforce the health system, but is also in-line with decentralization outlined in the Constitution.
- b) At the Health Zone level: one member of the ZMT, probably the Chief Medical Officer of the GRH, will train and supervise/coach 15-20 model Health Centers, initially on a monthly basis for the first three months and quarterly thereafter.
- c) At the Community Health Care Site level: the nurses in-charge (NIC) of the Health Centers and/or the Community Animator from the HZ Central Office will supervise/coach once a month in the first quarter and once per quarter thereafter. This method is based on the lessons learned and described in the document *Prise en Charge Communautaire Intégrée des Maladies de l'Enfant : Documentation des Meilleures Pratiques et des Goulots d'Etranglement à la mise en œuvre du programme en RDC*¹¹. To ensure an ongoing presence, each NIC will manage approximately 7 Community Health Care Site agents. Section 3.4 provides more details.

The availability of medicine is necessary for the structures described above to function effectively. Once again, the approach will be modeled on past public-private partnership experience to support a distribution system linked with the RDDs and the availability of cheaper medicines. The focus will center on local manufacturers, and will promote their role and strengthen their ability to locally manufacture quality drugs.

3.2 Overview of Key Outcomes and Deliverables

DRC's Millennium Development Goal 4 target is a child mortality rate of 66/1,000, as estimated in the Secretary-General's presentation entitled "*Evolution de l'état de santé de la population congolaise*" during the 2010 Annual Review of the Ministry of Health². To achieve this goal, the DRC has already proposed objectives and set targets in the National Health Care Development Master Plan (NHCDMP), the operational plan for the SRSS. Some of these objectives and targets are highlighted in the "Deliverables" and "Targeted Impact" columns to show how the Strategy presented here will help contribute to the GDRC's larger policies and objectives.

Key Interventions	Main Deliverables	Outcome Targets	Desired Impact
<p>1. Integrate the three national programs (NMCP, NARICP and NDDCP) under the leadership of Directorate 5 (to be confirmed)</p>	<ul style="list-style-type: none"> - Ministerial decree announcing the integration of the diarrheal disease, acute respiratory infection and malaria national control programs (NDDCP, NARICP and NMCP) and reorganization under the leadership of Directorate 5. - Identification, training and placement of one focal point at the national level, and one per province, district and HZ (GRH level, see Intervention 2). <ul style="list-style-type: none"> • National-level training-of-trainers for provincial focal points • Provincial-level training-of-trainers for district focal points - Finalization and formalization of integrated IMCI management document. - Dissemination of IMCI management document at all levels. - Review of DRC past experience with health financial incentives, forfaits, mutual health care insurance, community funds, and development of a motivation system for the public sector and community level. 	<ul style="list-style-type: none"> - Reduced fragmentation and increased consistency in Child Survival policy communications and dissemination. - 15% increase in the Directorate 5 budget compared to the individual budgets of the NDDCP, NARICP and NMCP (5% per year over 3 years). « La part du budget de la Santé augmente chaque année pour atteindre 15% du budget national d'ici 2015, son taux d'exécution augmente et la pertinence de l'affectation du budget de l'Etat consacré à la santé s'améliore⁴. »¹⁷ - 80% of care providers (public, private accredited and Community Health Care Site agents) identified under this strategy can correctly diagnose the three illnesses in accordance with IMCI standards (outcome related to Intervention 1, 2, 3 and 4). - 80% of care providers (public, private accredited and Community Health Care Site agents) identified under this strategy can correctly explain prevention and rational treatment of the three illnesses in accordance with IMCI (outcome related to Intervention 1, 2, 3 and 4). 	<p>Social and policy environment enabled (Obj. 1).</p> <p>(Contribution to National Health Care Development Master Plan (NHCDMP) Target 3, « maîtriser le paludisme et d'autres grandes maladies et commencer à inverser la tendance actuelle⁴. »¹⁸</p> <p>and to Strategy 3, R2, « R2. La fragmentation de l'aide internationale consacrée à la santé est progressivement réduite conformément à l'agenda de Kinshasa⁴. »¹⁹)</p>
<p>2. Identify or establish "model" HZs in the public sector (Public Sector)</p>	<ul style="list-style-type: none"> - 65 model HZ in place with existing minimum package (1 per district) = 65 GRH and 975-1,300 HC. - 36-65 ToT (training of trainers) trained (1 per 	<ul style="list-style-type: none"> - 80% of health districts have a model HZ trained in IMCI that serves as a reference. - 60% of the GRH and 15-20 HC in the model HZs had no stock-outs in the previous quarter. 	<p>Access to and availability of quality, primary health care services increased (Obj. 2)</p>

¹⁷ Translation: "The Health budget increases annually to reach 15% of the national budget by 2015, with improvements in its implementation rate and in the effectiveness of government funds allocated to health."

¹⁸ Translation: "Control malaria and other major diseases and begin reversing the current trend."

¹⁹ "R2. Fragmentation of international aid channelled to health gradually diminishes in keeping with the Kinshasa agenda."

	<p>district at the GRH/ZMT level) to train the HCs (1 GRH/ZMT trains 15-20 HC).</p> <ul style="list-style-type: none"> - 540-1,300 HC trained by one ToT GRH/ZMT. - Supervision: ensure planning such that each GRH receives at least one coaching/supervision visit per quarter, each HC and Community Health Care Site receives one supervision/coaching visit per month in the first quarter of its existence and once per quarter thereafter. 	<ul style="list-style-type: none"> - 70% of the GRH in the model HZs properly supervised the HCs in their area during the previous quarter. - 70% of HCs in the model HZs of the 5 provinces identified under Intervention 4 properly supervised the Community Health Care Sites in their area during the previous quarter. - 50% of facilities in the Model HZs use some type of health financial incentive, forfait, solidarity fund or community health fund system to motivate their staff. - 80% of care providers (public, private accredited and Community Health Care Site agents) identified under this strategy can correctly diagnose the three illnesses in accordance with IMCI standards (outcome related to Intervention 1, 2, 3 and 4). - 80% of care providers (public, private accredited and Community Health Care Site agents) identified under this strategy can correctly explain prevention and rational treatment of the three illnesses in accordance with IMCI (outcome related to Intervention 1, 2, 3 and 4). 	<p>(Contribution to NHCDMP Deliverable #284: « le taux d'utilisation des services curatifs est augmenté de 25%. Le taux d'utilisation des services de santé variant entre 0,15 et 0,25 contacts par habitant et par an passe à environ 0,40 à 0,50⁴»²⁰)</p> <p>and, to NHCDMP Target #7: « la proportion de la population qui a accès aux soins de santé primaires de qualité augmente de 30% d'ici 2015⁴»²¹)</p>
<p>3. Establish an accreditation program to regulate the private sector (Private Sector)</p>	<ul style="list-style-type: none"> - Workshop to determine how to build on MSH/SPS experience and incorporate regulations with the DPM. - Advocacy meeting with key members of the private sector (including wholesalers and micro financing banks) to jointly clarify mutual interests in an accreditation program, attractive incentives and a feasible approach. - Communications package to promote the program within the private sector (mass media and advocacy). - Creation/updating of the selection examination, if necessary. - Implementation of “mystery client” visits. - Identification, training and certification of 260 facilities (pharmacies, private health 	<ul style="list-style-type: none"> -80% of health districts have 2-4 government-accredited private facilities. - 60% of accredited private facilities had no stock-outs in the previous quarter. - 70% of accredited private facilities had one supervision visit per month in the first quarter. -70% of accredited private facilities had one supervision visit in the previous quarter (after the 1st qtr). - 80% of care providers (public, private accredited and Community Health Care Site agents) identified under this strategy can correctly diagnose the three illnesses in accordance with IMCI standards (outcome related to Intervention 1, 2, 3 and 4). - 80% of care providers (public, private accredited and Community Health Care Site agents) identified under this strategy can correctly explain prevention and rational 	<p>Access to and availability of quality, primary health care services increased (Obj. 2)</p> <p>(Contribution to NHCDMP Deliverable #284: « le taux d'utilisation des services curatifs est augmenté de 25%. Le taux d'utilisation des services de santé variant entre 0,15 et 0,25 contacts par habitant et par an passe à environ 0,40 à 0,50⁴»²⁰)</p> <p>and, to NHCDMP Target #7: « la proportion de la population qui a accès aux soins de</p>

²⁰ Translation: “The rate of curative service use increases by 25%.” “The rate of health service use, varying from 0.15 to 0.25 contacts per resident per year, climbs to approximately 0.40 to 0.50.”

²¹ Translation: “The percentage of the population that has access to quality primary health care increases by 30% by 2015.”

	facilities, NGO/faith-based organization sites with the aim of establishing 4 sites per district).	treatment of the three illnesses in accordance with IMCI (outcome related to Intervention 1, 2, 3 and 4).	santé primaires de qualité augmente de 30% d'ici 2015 ⁴)
4. Extend Community Health Care Sites under the authority of the HCs (Community)	<ul style="list-style-type: none"> - Identification of 1,175 Community Health Care Sites (5 per HZ in the 5 provinces of Bas Congo, Équateur, Orientale, Maniema and Sud Kivu). - 3,525 Community Health Care Site agents trained (3 per Site) in IMCI and managed by the HCs in the model HZs (an estimated 7 agents per HC). - Coach/supervision visits at least once a month in the first quarter and once per quarter thereafter. - Introduction of cStock at pilot sites with an action plan for extension to the remaining targeted sites if possible before or after 2015. - Creation of a Community Health Care Site agent motivation system. 	<ul style="list-style-type: none"> -60% of Community Health Care Site agents involved in the cStock pilot project had no stock-outs in the previous quarter. - 80% of Community Health Care Site agents identified under this strategy were monitored once a month in the first quarter. - 70% of Community Health Care Site agents identified under this strategy were monitored in the previous quarter (after the first quarter). - 30% of sites identified under the strategy use cStock to manage community supplies and motivate agents. - 80% of care providers (public, private accredited and Community Health Care Site agents) identified under this strategy can correctly diagnose the three illnesses in accordance with IMCI standards (outcome related to Intervention 1, 2, 3 and 4). - 80% of care providers (public, private accredited and Community Health Care Site agents) identified under this strategy can correctly explain prevention and rational treatment of the three illnesses in accordance with IMCI (outcome related to Intervention 1, 2, 3 and 4). 	<p>Access to and availability of quality, primary health care services increased (Obj. 2)</p> <p>(Contribution to NHCDMP Deliverable #284: « le taux d'utilisation des services curatifs est augmenté de 25%. Le taux d'utilisation des services de santé variant entre 0,15 et 0,25 contacts par habitant et par an passe à environ 0,40 à 0,50⁴» and, to NHCDMP Target #7: « la proportion de la population qui a accès aux soins de santé primaires de qualité augmente de 30% d'ici 2015⁴»)</p>
5. Promote the drug distribution system and local manufacturing of EMI drugs	<p><u>By 2015 :</u></p> <p>RDD</p> <ul style="list-style-type: none"> - GDRG provision of buildings for renovation to establish 2 RDDs. - Site renovation, equipment placement and operationalization. - Identification of members of the two RDDs and reinforcement of their capabilities. <p>Local Manufacturing</p> <ul style="list-style-type: none"> - Advocacy workshops - Audit of high-performing local manufacturers. - Business plan with local manufacturers. - Identification of feasible 	<p><u>By 2015:</u></p> <ul style="list-style-type: none"> - Establishment of 2 new RDDs. - Use of a local manufacturer's national distribution system to support the efforts of the National Essential Medicines Supply Program (NEMSP) and the RDDs. - An understanding of local production capabilities. -A PPP between the DRC and at least one local manufacturer. <p><u>Post-2015</u></p> <ul style="list-style-type: none"> - Local production of at least one EMI drug (i.e., ALu, pre-packaged ORS/zinc, dispersible Amoxicillin in doses for children <5). - Reduction in cost of treatment for clients. - At least 1 local manufacturer meets 	<p>Access to and availability of quality treatment increased (Obj. 3)</p> <p>(Contribution to NHCDMP Strategy 2, R1, « la disponibilité du médicament est assurée dans l'ensemble des ZS selon leur catégorie⁴. »²² and, to NHCDMP Strategy 2, R3, «80% des médicaments essentiels et génériques et intrants spécifiques</p>

²² Translation: "Medicine availability is ensured in all HZs according to their category."

	<p>plans and signature of public-private partnerships/MOUs with at least one local manufacturer.</p> <ul style="list-style-type: none"> - Establishment of links between manufacturer(s) and bank(s) and technical and financial partnerships. <ul style="list-style-type: none"> • Infrastructure renovation • Increased technical capability • Access to credit - Advocacy and political and technical support to launch the process of obtaining GMP status and to facilitate initial business plan activities. - Use of the manufacturer's distribution system, as necessary. - Manufacturer participation in prepackaging of an ORS/zinc pack (see Intervention 6). - Official launch to ensure coordination with the Initiative. <p><u>Post-2015</u></p> <ul style="list-style-type: none"> - Continued lobbying, renovation, reinforcement of capabilities, etc. - At least 1 local manufacturer obtains GMP status. 	<p>GMP conditions.</p>	<p>en circulation sont de bonne qualité en 2015 ⁴.» ²³)</p>
<p>6. De-medicalize ORS/zinc and ensure its universal coverage</p>	<ul style="list-style-type: none"> - Change in standards and policy to de-medicalize ORS and zinc and to promote a pre-packaged ORS/zinc kit. - Business plan with a local manufacturer (the same one identified under Intervention 5, if possible) for prepackaging (and local production, subject to approval). - Create innovative distribution systems for ORS and zinc, as well as water purifiers (brewers, merchants, hawkers, kiosks, markets, etc.). - Social marketing of a prepackaged ORS and zinc combination kit. 	<ul style="list-style-type: none"> - Ministerial decree changing policy. - National ORS/zinc distribution. - 65% universal coverage in ORS/zinc at the national level. - 60% of children under age 5 who had diarrhea in the two weeks prior to the survey in the intervention zones received ORS/zinc (outcome related to all of the other Interventions). 	<p>Access to and availability of quality treatment increased (Obj. 3)</p> <p>(Contribution to NHCDMP Strategy 2, R1, « la disponibilité du médicament est assurée dans l'ensemble des ZS selon leur catégorie ⁴»</p> <p>and, to NHCDMP Strategy 2, R3, «80% des médicaments essentiels et génériques et intrants spécifiques en circulation sont</p>

²³ Translation: "80% of essential and generic medicines and needed supplies in circulation are of good quality by 2015."

<p>7. Comprehensive Behavior Change Communications campaign</p>	<ul style="list-style-type: none"> - Use of organized community structures in the HZs. <ul style="list-style-type: none"> • Identify 130 community structures (2 per district) • 260 representative members trained (2 per association) in entrepreneurship, BCC and program management. • Enter into contracts with community structures for BCCs at the interpersonal level (small grants). - Mass Media: Ambassador of Change program. <ul style="list-style-type: none"> • Identification of ambassadors among stars/celebrities, religious and political leaders, journalists, etc. • High-profile mass media campaign conducted by these ambassadors (i.e., song competition, etc.). - Ownership promotion campaign among key technocrats (ZMT, DMT and Focal Points), care providers (CMO and NIC) and academics. <ul style="list-style-type: none"> • Visits to model Community Health Care Sites and private facilities. • District-level campaign launch with the district/provincial chief medical officer as guest of honor. 	<ul style="list-style-type: none"> - Increase from 44% to 60% the % of caregivers of children from 0-23 months of age who can identify at least one serious symptom of the three diseases that requires early care-seeking. <ul style="list-style-type: none"> • Increase to 60% the % of caregivers of children under age 5. • Increase to 80% in intervention zones for children from 0-23 months and 0-5 years of age. - Increase from 8% to 25% the % of caregivers who can identify at least two danger signs of pneumonia. <ul style="list-style-type: none"> • Increase to 40% in intervention zones. - Increase from x% to y% the % of caregivers who can identify at least two danger signs. <ul style="list-style-type: none"> • Increase from x% to y% for diarrhea. • Increase from x% to y% for malaria. • Distinction between nationwide and intervention zones. • Effort to identify baselines before setting percentages. - x% of private facilities and sites with at least one support activity included in the Health District performance review (baseline % TBD). - (Re)establishment of an “active” budget line at the provincial level to support site activities. - HZs take into account Community Health Care Sites supply needs when submitting orders to the Health Zone Central Office (HZCO) 60% of the time. - One semi-annual visit apart from the supervision visits per private facility and organized site. 	<p>de bonne qualité en 2015 ⁴)</p> <p>Demand for quality, primary health care services and positive behavior increased. (Obj. 4)</p> <p>(Contribution to NHCDMP Deliverable #284: « le taux d'utilisation des services curatifs est augmenté de 25%. Le taux d'utilisation des services de santé variant entre 0,15 et 0,25 contacts par habitant et par an passe à environ 0,40 à 0,50 ⁴»</p> <p>and, under Target 3: « maîtriser le paludisme et d'autres grandes maladies et commencer à inverser la tendance actuelle ⁴. » ²⁴</p> <p>and, under Target 8 : « la proportion d'enfants < 5 qui reçoivent un traitement correct au paludisme/fièvre augmente de 25% à 80% ⁴. » ²⁵</p>
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HZ = Health Zone, HC = Health Center, CHCS = Community Health Care Site

²⁴ Translation: Control malaria and other major diseases and begin reversing the current trend

²⁵ Translation: Increase the percentage of children < 5 who receive proper treatment for malaria/fever from 25% to 80%.

3.3 Detailed Description of the Targeted Interventions

1. Integrate the three national programs (NMCP, NARICP and NDDCP) under the leadership of Directorate 5 (to be confirmed)²⁶

Rationale: Currently, the DRC MoH is composed of many directorates (13 Directorates), national programs (52 NP) and projects that target diseases or specific intervention areas. The composition situation fosters fragmentation, verticalization and inefficiency with respect to child survival interventions. MOH central level reform is one of the key areas highlighted in the SRSS as stated in the NHDMP. The complexity of the current central level organogram makes multi-sectorial coordination difficult. It is, therefore, necessary to revise the organogram and organization, in alignment with the competencies assigned to each level in the Constitution. In addition, it is important to ensure that those filling each position have the proper profile. Recognizing this need, the Strategy plans to integrate the specialized national programs within the directorates through focused restructuring of the Directorates. In order to promote better coordination of activities involving the administration of primary health care related to child survival, the Strategy proposes to support the integration of the three child survival programs (NMCP, NARICP and NDDCP) under the leadership of Directorate 5 (to be confirmed).

The DRC MoH has already planned for central level Directorate restructuring to take place. Due to its importance, the Strategy approach is to support this GDRC initiative through advocacy, technical support to design the integration, policy document development, long-term action and financial plan development and the establishment of focal points.

Approach: Building-on the SRSS's reinvigorated primary health care focus, Directorate 5 will take the lead in developing primary health care. It will identify and designate the focal points at all levels, through its existing structure, and will work closely with Directorate 10 to finalize and formalize the IMCI management documents. A ministerial decree will announce Directorate 5's leadership in this area, and the integration of the specialized national programs, including NMCP, NARICP and NDDCP. Technical and financial partners will be identified to support implementation and capacity-building.

The focal points will be the Division Head for the Health Care Strategy who sits within Directorate 5 at the central level, the five Bureau Chiefs at the provincial level, the Chief Medical Officers at the district level and the Managing Physicians at the GRHs or other members of the ZMT at the HZ level. These positions will form the coordination base in terms of working with other structures and existing projects, quality assurance for services and the implementation of training and supervision. The central level (national focal point) will provide supervision and support at the intermediate level (provincial and district focal points). These focal points will also work in close technical collaboration with the coordinators designated by the technical and financial partners for better coordination. The DRC MoH will manage these positions through the 5th Bureau.

The provincial focal points will ensure technical IMCI assistance at the provincial level, synergy and coordination of IMCI interventions with the other provincial structures of the MOH (PMT, Bureau, etc.), and proper implementation of activities within the province. They will also organize the training, supervision and motivation of the district health focal points. At the district level, the focal points will be the first in the districts to coordinate the IMCI interventions with the other structures (DMT and ZMT, HZCO, etc.). Responsibilities will include other activities, such as promoting IMCI policies, organizing the training sessions (see the interventions below), providing supervision and support for Child Survival and ICMI in addition to motivating the IMCI players. They will play an important role in supporting and supervising the health facilities (public, private and community) in their district. They will also do the planning with the model GRH and the model HC to ensure that each public and accredited private facility or Community Health Care Site receives the forecasted coaching/supervision. At the level of the Health Zone, the CMO of

²⁶ The national programs will be integrated based on the MoH internal reorganization currently in progress. If the MoH decides to incorporate these programs into one or several other directorates, the strategy will comply with the MoH decision. In this document, the title of Intervention 1 includes the words *to be confirmed* to highlight this situation.

the model GRH, who is part of the ZMT, or another member of the ZMT, will be the HZ focal point. This individual will provide training and supervision/coaching to the 15-20 model Health Centers. Initially, this will be done monthly and then quarterly. In the event that this person should not be available, he or she will appoint a replacement from the HZ Management Team (ZMT).

The focal points will also play an important role in developing a motivation system for the health facilities, especially the public and community structures, that ultimately will complement a health funding plan to help the population cover health costs. The DRC has already identified a number of HZs with financial incentive systems that have been linked to a "notable" increase in the rational use of health services on the part of the general population, and « la meilleure utilisation des services a amélioré le recouvrement des coûts dans les deux zones de santé »²⁷ pilots ^{3, pg.37}. Cost recovery motivates the health care facilities, and in the case of these initiatives, comes from an increased number of patients seeking curative health services and pay for those services. In one case, the financial incentive system is a « forfait comme mode de tarification à deux échelons ^{3, pg.37}. »²⁸ As another example, mutual health care insurance was established in the Kisantu HZ in Bas Congo ³. The Lubunga HZ is trying out « l'inscription payante de la population au centre de santé et l'organisation par la communauté d'un fonds pour le financement des soins au premier niveau de référence ^{3, pg. 37}. »²⁹ There has also been some experience with health care grants contracted to health care providers, such as the implementation of a fund for purchasing services (FPHS, or fonds d'achat de services (FASS)) under PS9FED and the solidarity fund tested under MEMISA ^{3, pg. 37-38}. The focal points will need to analyze these experiences, discuss them with the care providers and support the identification of the best practices to be promoted in each health district.

Based on the lessons learned from other experiences, such as the experiences from implementing iCCM, this strategy includes long-term planning of national program activities and the estimation of need at each level (with the participation of the local authorities, civil society, etc.) ^{11, pg.31}. The long-term planning will help ensure that activities are organized and integrated and will also contribute to the sustainability of the initiative.

Activities and Main Deliverables:

- (a) Study visit to Senegal, a country which is quite advanced in the area of integrated Child Survival.
- (b) A ministerial decree will announce the leadership of Directorate 5 in this area and the integration of the three national programs (NMCP, NARICP and NDDCP) under its leadership, including a long-term action plan and budget.
- (c) Coordination and synergy meetings twice a year with the other partners and Directorates, under the leadership of Directorate 5.
- (d) Identification, training and placement of a focal point for Directorate 5 at the national level and one in each province, health district and model HZ (see Intervention 2) followed by cascaded training sessions at the national, provincial, district and HZ levels, respectively, facilitated by Directorates 5 and 10, the national focal point and the provincial focal points.
- (e) Coaching/supervision: the idea is to provide a plan for each focal point to receive at least one coaching/supervision visit per quarter from his/her superior (from the national focal point and/or other members of Directorate 5 and partners for the provincial focal points, from the provincial focal points for the district focal points, from the GRH/ZMT for the HCs and the HZs). Specifics regarding the supervision schedule are provided in the Interventions below.
- (f) Finalization and formalization of the IMCI management document:
 - Analysis of Cotrimoxazole versus dispersible Amoxicillin, and ALu versus ASAQ as first-line therapies (analysis to be done as part of the IMCI management document deliverable)
 - Integration of training on algorithms and RDT results.
- (g) Dissemination of the IMCI management document through the project structure: from the national focal point to the Community Health Care Sites by way of the provincial focal points, the district focal points, the model GRH and accredited private facilities and model HC.

²⁷ Translation: "better use of the services has led to increased recovery of costs in the two [pilot] health zones"

²⁸ Translation: "a two-tier forfait model."

²⁹ Translation: "paid registration of the population at the health center and a Community Health Fund for primary health care."

- (h) Analysis of DRC's experience with health care financial incentives, forfaits, mutual health care insurance and community funds, and development of a motivation system for the public sector and the community level.

2. Identify or establish "model" HZs in the public sector (Public Sector)

Rationale: In the DRC, the low level of access to quality primary health care services is the most significant barrier to universal coverage for ORS/zinc, dispersible Amoxicillin/Cotrimoxazole and ACT, as it is estimated that about 70% of patients in this country do not have access to modern health services³. Despite all the efforts to respond to challenges related to access, early care-seeking and quality of service at the HZ level, as proposed in the SRSS, there is still a gap of about 269 HZs, or more than half of the HZs, that are not receiving support. It seems unlikely that it will be possible to close that gap by 2015 using a traditional 100% public sector approach. It is for this reason that this project is proposing an integrated approach involving the public, private and community sectors. Intervention 2 focuses on the public sector portion.

In terms of the public sector, the DRC has already identified six model HZs in the country « qui ont pu résister et qui gardent un degré de fonctionnement appréciables ^{3, pg. 36, »³⁰ despite the advanced decline of the health care system. The SRSS cites cases such as « Katana (province du Sud Kivu), Kyondo, Kayna, Rutshuru, Kirotshe (province du Nord Kivu) et Pawa (province Orientale), qui fonctionnent encore à ce jour avec une assez bonne articulation entre l'hôpital général de référence et les centres de santé ^{3, pg. 36, »³¹. The SRSS cites these HZs as models that should be copied, given their positive experience. Lessons learned from these six HZs should be used as the basis for establishing one model HZ per district.}}

Approach: In terms of the public sector, the goal is to establish at least one model HZ per district in order to improve the quality of health services. It is important to have model health facilities able to coordinate and work in synergy with private facilities and community health care sites in order to rapidly advance toward universal coverage. Partners already have a strong presence in 29 districts and it is estimated that in these districts, there will already be at least one model GRH and about 15 to 20 HCs implementing a minimum package of services that can be identified for strengthening. It is estimated that the remaining 36 districts will require complete capacity-building in order to establish one model GRH and 15 to 20 HCs in the HZs concerned. The identification and selection of the HZs that should be targeted to become model HZs will be based on criteria including lessons from the 6 model HZs already identified in the SRSS, the mortality and morbidity rates, the curative service usage rate and the criteria listed in the NHDMP for the development of the HZ in 2011-2012.

For this intervention, Directorate 5 will take the lead with support from Directorate 10 and the national focal point. The focal points will support the mobilization required at the district level to identify the HZs and model facilities. Technical and financial partners will be identified to support initial implementation and capacity-building.

Activities and Main Deliverables:

- (a) Training: The model facilities will be trained using the IMCI management document finalized under Intervention 1.
- i. 36-65 trainers (1 per district at the GRH level) trained by the district focal point and/or the pool of trainers that have already been trained under other projects at the provincial level, will then provide training to the 15 to 20 HCs in their HZ. There will be 36 trainers if the 29 HZs in the 29 partner-supported districts are strong enough to more immediately be named as model HZs, otherwise the number may increase to 65, if there is not even one GRH that can immediately be named as a model.
 - ii. 540-1300 HCs trained by the GRH trainer.

³⁰ Translation: "that remain intact and have been able to maintain an impressive degree of operationality"

³¹ Translation: "Katana (a province in Sud Kivu), Kyondo, Kayna, Rutshuru, Kirotshe (a province in Nord Kivu) and Pawa (a province in Orientale), that are still operating today with good linkages between the general referral hospital and the health centers."

- (b) Coaching/supervision: the plan is for each GRH to receive at least one coaching/supervision visit per quarter, and for each HC and Community Health Care Site to receive one coaching/supervision visit in the first quarter of its existence, and in each quarter thereafter (see Intervention 4)
 - i. The district focal point will provide coaching/supervision for the GRH in its district and the private accredited facilities (see Intervention 3)
 - ii. The ZMT representative will provide coaching/supervision for the HC
 - iii. The Nurse In-Charge at the HC will provide coaching/supervision for the Community Health Care Sites (see Intervention 4, below).
- (c) Motivation: As explained in Intervention 1, better patient use of the services increases the recovery of costs, which leads to payment for care provided at health facilities, which ultimately leads to increased motivation. The strategy is to study DRC's experiences in terms of health financial incentives, mutual health care insurance, community funds with paid registration at HCs, a fund for purchasing health services (FASS), as well as solidarity funds³.

3. Establish an accreditation program to regulate the private sector (Private Sector)

Rationale: A traditional public sector and/or community approach will probably not be sufficient to reach universal coverage in the DRC by 2015. Integrating the private sector into the approach may be the solution needed to overcome the scale-up challenge. As indicated above, the private sector is robust in the DRC with a long history of collaborating with public institutions in the management of health services. « Des organisations religieuses et des ONGs gèrent un nombre important de centres de santé et la moitié des hôpitaux ^{12, pg. 1} »³² and ACTWatch estimates that the source of treatment for children with a fever is a pharmacy 40% of the time, and a private health facility 10% of the time⁹. The SRSS also explains that there are a large number of private/informal health structures outside the health system due to a dramatic increase in the number of Medical Technical Institutes that are training care providers in numbers that exceed demand in preferred geographic zones ³. « Le nombre des diplômés des ITM est passé d'une moyenne annuelle d'environ 1.500 entre 2001 et 2005 à environ 3.000 et plus entre 2007 et 2009 ^{3, pg. 15} »³³ The problem with access to quality services is, therefore, not a matter of private-sector care provider availability or the level of training, but rather is a matter of including them in the regulation and supervision of the formal health system at the Health Zone level.

The need to integrate private health facilities into the health system is not unique to the DRC, and there is important experience elsewhere in Africa that supports this approach. As described in the article by Rutta E, Senauer K, et al, *Creating a New Class of Pharmaceutical Services Provider for Underserved Areas: The Tanzania Accredited Drug Dispensing Outlet Experience*, "The ADDO program in Tanzania provides proof of concept and lessons on how an innovative public-private initiative can address shortages in the number of qualified health care providers by training and accrediting retail drug dispensers to recognize and treat common conditions and provide quality pharmaceutical products and services ^{18, pg. 152}." One experiment is already underway in the DRC, under the SPS, to introduce IMCI in the private sector in the DRC. It is described in the baseline study document by Kinsaku BM, Bukasa G, and Diarra S, written in September 2009 entitled *Connaissances et pratiques du personnel des pharmacies privées sur la prise en charge des maladies de l'enfant dans deux zones de santé de la Ville-Province de Kinshasa, République Démocratique du Congo, août 2009 : Rapport des résultats d'enquête*. The baseline study concludes that « Le secteur pharmaceutique privé évolue comme en dehors du système de santé et les différents protocoles nationaux de lutte contre ces trois maladies ciblées ne sont ni connus ni diffusés au niveau du secteur privé. Les résultats de cette étude permettent d'affirmer qu'il y a un besoin en renforcement de capacités du personnel des pharmacies privées pour la prise en charge des infections respiratoires aiguës, du paludisme et de la diarrhée. En outre, le secteur privé devra être pris en compte dans la mise en œuvre des différentes stratégies pour la réduction de la mortalité infantile et infanto-juvénile ^{19, pg. ix} »³⁴ This strategy will build-on MSH/SPS's

³² Translation: "Faith-based organizations and NGOs manage a significant number of health centers and half of the hospitals"

³³ Translation: "The number of MTI graduates climbed from an annual average of approximately 1,500 between 2001 and 2005 to approximately 3,000 or more between 2007 and 2009." ^{3, pg. 15}

³⁴ Translation: "The private pharmaceutical company sector is evolving outside of the health system, and the different national protocols to combat the three targeted diseases are not known or publicized at the private sector level. The results of this study confirm that there is a need to strengthen the capacity of private pharmacy staff to manage acute respiratory infections, malaria

experience piloting IMCI integration into the private sector in two HZs, and will make use of the lessons learned from the more advanced ADDO experience in Tanzania.

Approach: The objective is to identify and accredit 2-4 private facilities (pharmacies, private health facilities, NGO/faith-based structures, etc.) per district. The initial focus will be on promotion and advocacy among private sector structures to convince them of a positive return on their investment if they contribute to their own participation (examination and training costs, etc.). Based on the lessons learned from Tanzania's ADDO experience, the promotion aspect will highlight important private sector incentives, such as increased visibility and branding, access to affordable business management training, and financial benefits from (exclusive) ties with wholesalers and microfinance banks¹⁸. To reduce the costs associated with identifying the facilities and the training, an important lesson learned from Tanzania is that training sessions will be grouped together with regular public sector training in the district. Also based on the Tanzanian experience, the private facilities interested in participating will be asked to assume a large portion of the costs associated with their accreditation, for example, they will cover their own exam and training fees¹⁸. Given the important financial contribution expected of the private sector, the initial promotion and advocacy discussions with the private sector are crucial in order to understand their needs and interests from the beginning.

One of the reasons cited for the ADDOs success in Tanzania is that the Tanzania Food and Drug Association (TFDA) has taken the lead and provides strict regulations at all levels¹⁸. The major challenge in the DRC will be supporting the DPM to take the lead and establish the needed regulations, given that the DPM has limited resources. Directorate 5, using its basic structure, will help with supervision, and technical and financial support will be put in place from the beginning to strengthen the capacity of the DPM to assume the leadership role. A significant amount of work with the DPM at the beginning will be important to create links to the DPM and establish a sustainability plan.

Activities and Main Deliverables:

- (a) Meetings/workshops to present the results of the IMCI Private Pharmaceutical Sector pilot project conducted by MoH/SPS and executives at the MoH. Lessons learned will be analyzed by meeting/workshop stakeholders and participants to determine an appropriate scale-up approach aligned with DRC regulations.
- (b) Advocacy meetings with key players from the private sector (including wholesalers and microfinance banks) to clarify mutual interests, the incentives that will be of interest to them and a viable approach.
 - a. A communications package to promote the program within the private sector (mass media and advocacy).
- (c) Identify the private facilities: To identify potential facilities/structures to accredit, the project will create and/or update a written examination available at specific sites. The facilities/structures that pass the written examination will receive a "mystery client" visit from the focal point, the GRH trainer or another person identified by the project to ensure the quality of the services in place. Each facility/structure will receive a mark that places it in one of the following four categories: excluded, complete training needed, short-format training needed, no training needed/ready.
 - a. Create/update the selection examination.
 - b. Implement the "mystery client" visits.
- (d) Training: Those who are "ready" will be certified/accredited immediately. Candidates for complete training will receive the same training at the same time as the 15 to 20 Health Centers in their district, so there will be no need for special training. As for candidates for the short-format training, they will attend just the beginning of the complete training in their district. All facilities/structures that have been trained will receive a "mystery client" visit after the training and prior to certification.

and diarrhea. Moreover, the private sector must be taken into account in the implementation of the different strategies to reduce infant and child mortality."

- (e) Supervision: The district focal point, and from time to time the provincial focal point, will provide coaching/supervision to private accredited facilities once a month in the first quarter and once per quarter thereafter.
- (f) Motivation/Incentives: Based on the lessons learned from the ADDO experience in Tanzania, the motivating elements are: more clients due to accreditation visibility, return on investment, training in managing a business, (exclusive) ties with wholesalers and ties with the microfinance banks¹⁸.
- (g) Overall: identify, train and certify 130-260 facilities (pharmacies, private health facilities, NGO/faith-based sites, etc.), or 2-4 per district.

4. Extend Community Health Care Site coverage under the authority of the HCs (Community)

Rationale:

There is a long and rich history of experience with integrated management of malaria, diarrhea and pneumonia at the community level in DRC. IMCI-C community health care sites first started to be set-up to promote c-IMCI in the end of 2005. As explained in the Policy Statement of the National Diarrheal Disease Control Program (July 2008)⁸, and the NDDCP National Standards and Directives (August 2008)¹⁶, « la communauté [organisé dans un Site des Soins avec des Relais de Site] fait la promotion des mesures préventives, prend en charge les cas simples, notifie et réfère les cas avec signes de danger aux Centres de Santé^{8,pg.15}. »³⁵ Community IMCI focuses on promoting key practices and simple case management through the Community Health Care Site agents at the community level¹⁶, under the responsibility of the HC. The Community Health Care Sites in the community are not parallel structures; they fall under the responsibility of the HC. These Community Health Care Sites mobilize and organize the community to implement the c-IMCI activities, such as home visits, and to strengthen early referral to and care-seeking at the HC. They contribute to increasing the curative services usage rate at the HC level, which is the main structure tasked with managing primary health care.

Under NDDCP/c-IMCI coordination, a number of partners have contributed to the implementation and extension of this approach in the DRC, in particular, NDDCP, BASICS/MCHIP, IRC, Project AXxes, CIDA/PSI, UNICEF, WHO and currently, PROSANI/MSH. To date, the c-IMCI coordination database indicates there are 1,228 Sites for managing simple cases of malaria, diarrhea and pneumonia in children under five. In some cases, these sites experience difficulties continuing operations due to stock-outs and problems related to the attrition of trained Community Health Care Site agents. The document entitled *MCHIP Documentation of mature national iCCM program: the Case of the Democratic Republic of Congo*, indicates that "The role of CHWs in CCM is fundamental in extending essential services to hard-to-reach populations^{20, pg. 2}." Despite the existence of 1,228 sites already, experts estimate that there is a need for at least 10 sites per HZ, or an estimated 5,150 sites, leaving a 76%-88% gap in Community Health Care Site coverage. It is not likely that it will be possible to close the gap by 2015. As such, the Strategy aims to introduce an integrated public, private and community sector approach. Intervention 4 focuses on the community aspect.

Approach:

After a one-week workshop, including an analysis of past experiences and current Community Health Care Sites mapping, the authors of this Strategy (the working group in concert with the consultant), propose an extension and strengthening of the Community Health Care Sites supported by existing projects in the HZs that are the poorest, the most remote and that have the highest mortality rates: Bas Congo, Equateur, Orientale, Maniema and Sud Kivu. The private and public sector approaches will ensure visibility at the national level while the community approach will further deepen the impact in the five key provinces.

Despite a focus on the five provinces, it is still unlikely to reach ten sites per HZ. Efforts will, therefore, be focused on five sites per HZ that are the poorest, the most remote and that have the

³⁵ Translation: "the community [organized into a Community Health Care Site with CHCS agents] promotes prevention, manages simple cases and reports and refers cases with danger signs to the Health Centers."

highest mortality rate, for a total of 1,175 sites. The DRC has only reached 1,228 sites in seven years, due to the initial groundwork to implement a favorable policy environment, create technical and operational documents, and establish a support structure. Given the prior groundwork and lessons learned, the expectation is that Community Health Care Sites can be established more quickly. According to the document entitled *Prise en Charge Communautaire Intégrée des Maladies de l'Enfant: Documentation des Meilleures Pratiques et des Goulots d'Etranglement à la mise en œuvre du programme en RDC*, there are already « documents technique et opérationnel bien codifiés, existants et disponibles » pour la mise en œuvre, la formation et la supervision ^{11, pg.60}. »³⁶ There is also a pool of trainers who have been trained using the provincial training modules and techniques in 10 of the 11 provinces, and the experience has been documented to « éclairer la prise de décisions sur la mise en œuvre du programme en RDC ^{11, pg. 5}. »³⁷ The Strategy will build-on the experience and partner network already in place in order to achieve the expected outcomes of Intervention 4.

Stock-outs at the sites¹¹ constitute one of the bottlenecks already mentioned above and one of the reasons why half of the HZs are not considered operational. According to the document entitled *Prise en Charge Communautaire Intégrée des Maladies de l'Enfant: Documentation des Meilleures Pratiques et des Goulots d'Etranglement à la mise en œuvre du programme en RDC*, « Depuis une enquête menée en 2008 au niveau des sites des soins communautaires dans trois provinces³⁸, il n'y a pas eu beaucoup de changements en RDC. Cette enquête a constaté d'importants problèmes de disponibilité : à titre d'exemple, dans le Kasaï occidental, seulement 24% des sites avaient de l'ACT pour traiter le paludisme ; dans la province de Bandundu, il n'y a avait pas d'ACT (même au niveau des centres de santé)...dans la province de Kinshasa, seulement 55% des sites possédaient de l'ACT ^{11, pg. 40}. »³⁹ This strategy will attempt to meet this challenge by introducing cStock into the supply management system for the sites. Knowledge of cStock comes from "Supply Chain 4 Community Case Management (SC4CCM)" managed by JSI in Malawi. As described in the JSI document entitled *cStock: Creating an SMS system to improve supply of child health medicines for CCM in Malawi*, "cStock is a rapid SMS, open-source, web-based system that was custom designed by SC4CCM for monitoring and managing community-level essential medicines and commodities for child health, family planning and HIV testing. The system allows HSAs [Health Surveillance Assistants, otherwise known as Community Health Workers] to transmit their stock information to the HC and allows community level data, previously unavailable, to be visible to decision makers at all levels of the system ^{21, pg.1}." The use of cStock in the DRC could strengthen the ties between the Site agents and the HC in terms of restocking and may help the HC to better monitor supplies at the community level. The introduction of cStock and its tools to support supply chain management may help the HC to not "forget about" the Community Health Care Sites when procuring from the HZCO.

Directorate 5 will take the lead, with technical assistance from Directorate 10. Technical and financial partners will be identified to provide support for implementation and capacity-building.

Activities and Main Deliverables:

- (a) Update the Community Health Care Site mapping and situation analysis. If necessary, basic renovation of some existing sites.
- (b) Identify the 1,175 target Community Health Care Sites (5 per HZ in Bas Congo, Equateur, Occidental, Maniema and South Kivu), and identify the 3,525 Community Health Care Site agents (3 per Site). Based on the lessons learned, the team will consider « la priorisation des

³⁶ Translation: "standardized technical and operational documents that exist and are available" for implementation, training and supervision."

³⁷ Translation: "shed light on the decisions that are important when implementing the program in the DRC."

³⁸ Mbumba Kinsaku. B., et G. Bukasa Kaleka. (2008), Disponibilité et dispensation des médicaments essentiels au niveau des sites des soins communautaires des provinces du Kasaï occidental, Bandundu et Kinshasa en la République Démocratique du Congo, USAID/MSH Strengthening Pharmaceutical Systems

³⁹ Translation: "Since a survey was carried out in 2008 at the Community Health Care Sites in three provinces ³⁸, not much has changed in the DRC. The survey showed that there are significant problems related to availability. For example, in Western Kasaï, only 24% of the sites had ACT to treat malaria; in the province of Bandundu, there was no ACT (not even at the health centers); in the province of Kinshasa, only 55% of the sites had ACT."

REPRO [Relais Promotionnels] répondant aux critères lors du recrutement des RS au début de la mise en œuvre dans une aire de santé ^{11, pg.48}. »⁴⁰

- (c) Training: 3,525 CHW will receive IMCI training « pendant 5 jours par le pool de la province ou du district en collaboration avec les Infirmiers Titulaires qui les supervisent ^{11, pg.32}. »⁴¹ It is estimated that each HC (Nurse In-charge) will manage about 7 site agents, as shown in Table 5, below.

Table 5	Districts	Health Zone	Community Health Care Sites (5 per HZ)	Trained HCs (estimated at 15 per district)	Community Health Care Sites per HC	3 agents per Community Health Care Site	Agents per HC
Bas Congo	5	31	155	75	2	465	6
Equateur	8	69	345	120	3	1035	9
Occidental	10	83	415	150	3	1245	8
Maniema	4	18	90	60	2	270	5
Sud Kivu	5	34	170	75	2	510	7
TOTALS	32	235	1175	480		3525	7

- (d) Coaching/Supervision: Based on lessons learned, « afin d’assurer la qualité et la performance des relais, la stratégie prévoit trois catégories d’appui : des réunions de suivi post-formation, des visites de supervision de routine et des supervisions des superviseurs. ... Une série d’au moins trois suivis espacés d’un mois est d’abord prévue : le premier suivi intervient 4 à 6 semaines après l’installation officielle des relais. La recommandation est d’en faire un par trimestre mais au moins 2 fois par an [après les premiers trois suivis] ^{11, pg. 49}. »⁴²
- Post-training follow-up meetings: « Reconnaissant que la faisabilité de supervision par les IT à partir de leurs centres de santé reste incertaine, la stratégie a fondé le renforcement des capacités post-formation sur les réunions de suivi qui rassemblent les cohortes des relais des sites pour des sessions d’une journée ^{11, pg. 49}. »⁴³ Usually, after two post-training follow-up meetings, most agents perform well and can begin the process of routine supervision¹¹.
 - Routine supervision: Conducted by the HC Nurse In-charge with support from the Community Animator at the Health Zone Central Office. Sometimes, they receive support from officials from the next supervisory level, such as the focal points.
- (e) Supervision for supervisors: as indicated in Intervention 2, the GRH/Health Zone Central Office will provide capacity-building and supervision/coaching to the Nurse In-charge/Health Center. This will help them to better coach and support the agents.
- (f) Motivation: The use of volunteer Community Health Care Site agents is often at the heart « aux débats de la pérennisation ^{11, pg. 7}, »⁴⁴ but at a minimum, in the DRC, it has been found that « le taux de rétention est bon ^{11, pg.34}. »⁴⁵ Lessons learned in Senegal and the DRC suggest recommendations for sustainable monetary and non-monetary motivation:

Non-monetary motivation:

⁴⁰ Translation: "prioritizing the recruitment of Promotional Relays [Promotional agents] that meet the criteria before beginning activity implementation in a health area."

⁴¹ Translation: "over a period of 5 days, by trainers from the provincial or district pool, in collaboration with the Nurses In-charge that supervise them."

⁴² Translation: "in order to ensure the quality and performance of the Relays [agents], the strategy involves three categories of support: post-training follow-up meetings, routine supervision visits and supervision for the supervisors. A series of at least three follow-up meetings, one month apart, has been initially planned: the first follow-up meeting will take place four to six weeks after the agents officially begin their duties. The recommendation is that supervision takes place once per quarter and at least twice per year [after the first three follow-up meetings]."

⁴³ Translation: "Given that it is uncertain whether or not the NIC can feasibly carry-out regular supervision visits, the strategy based post-training capacity-building on the one-day post-training follow-up meetings for the Relay [CHCS agent] cohorts."

⁴⁴ Translation: "of sustainability debates"

⁴⁵ Translation: "the retention rate is good."

- a. Ensure at least the minimum stock supply necessary for case management: Based on the JSI experience in Malawi and with technical support from JSI, a pilot introduction of c-Stock will be rolled out at a limited number of sites prior to 2015, with an extension, if possible. At a minimum, an action plan will be developed to ensure an extension of the cStock experience beyond 2015.
- b. Regular supervision and post-training follow-up with the NIC, to be done jointly with the focal points. « Ces supervisions...sont aussi perçues comme facteur de motivation des relais et surtout de confiance pour la communauté, au vu de la présence de l'IT ou du médecin-chef de zone au niveau du site ^{11, pg. 49}. »⁴⁶ The optimal number of post-training follow-up meetings during the initial stages of Community Health Care Site establishment is 5, not only in terms of agent capacity-building, but also in terms of agent motivation.
- c. Incentives: membership cards¹¹, meetings with health facility care providers, « la participation des relais aux réunions trimestrielles de monitoring ^{11, pg. 35}, »⁴⁷ etc.

Financial/Monetary motivation:

- d. Should volunteer community health workers be paid or not? A great deal has been said and written about this topic, all over the world. In the DRC, the national policy does not support paying community agents, given the voluntary nature of their duties and the issue of sustainability. Most donors do not support community health workers salaries either. In light of the socio-economic context, lessons learned from DRC's experience with Community Health Care Site agents recommend reimbursement for travel costs associated with an agent's submission of site reports to the NIC at the HC, assuming that they do not have access to bicycles. If possible, however, the optimal solution is « la dotation des moyens de déplacement (vélos) ... ^{11, pg. 35} »⁴⁸ which is not only helpful in terms of submitting reports, but which also acts as a form of agent motivation. Agents are motivated when they receive a bicycle because it not only can be used for work purposes, but also for personal reasons.

5. Promote the drug distribution system and local manufacturing of EMI drugs

Rationale: Only 10% of medicines are manufactured locally in the DRC, while 90% are imported³. This reality increases the price of drugs, extends procurement lead times and can create the possibility of lengthy stock-outs in the absence of a strict monitoring system. In DRC, the operation of the NEMSS is based on the RDDs, but only 15 out of the needed 26 are operational. DRC's supply chain challenges play a significant role in the low level of access to and availability of essential medicines, especially given that the population is poor and that the price of health services and treatment figure largely in the decision to seek care or not. The low level and standard of quality with respect to local manufacturing and the lack of a stable distribution system make it difficult for DRC to face its supply chain bottlenecks. Of the local pharmaceutical laboratories such as ZENUFA, Cesamex, Phatkin, Pharmakina, and many others, there is not one that meets the "Good Manufacturing Practices" (GMP) standards required by the WHO. Consequently, donors and financial partners are not willing to buy from these local manufacturers and thus these local manufacturers do not benefit from the large procurement orders coming into their country. Without the profit from large procurement orders and/or other support, it is difficult for these manufacturers to make the investment required to upgrade to the GMP standards. Given their private sector status, it is also difficult for them to get support in obtaining the necessary credit and loans from banks in order to upgrade. In order to upgrade, manufacturers need additional investment in terms of infrastructure and capacity building, facilitated access to credit and a commitment from donors and financial partners to purchase supplies from them, once the standards have been met.

Linking the local manufacturing network into the health system is a "win-win" opportunity. The manufacturers win in terms of large procurement orders and turnover. The public sector wins by reducing the cost of drugs and gaining access to the local manufacturer's extensive distribution network. The "win-win" nature is the basis of a true public-private partnership.

⁴⁶ Translation: "Such supervision...is also seen as a motivating factor for relays [CHCS agents] and, above all, raises the level of confidence within the community, given the presence of the NIC or the Zone Head Physician at the site."

⁴⁷ Translation: "Relay [CHCS agent] attendance at quarterly monitoring meetings"

⁴⁸ Translation: "to provide a means of transportation (bicycles) ..."

Approach: Intervention 5 will take time because the DRC is starting from scratch. Even in Tanzania, where Shelys began the process several years ago, nothing has yet come to fruition. It is, therefore, more realistic to plan the approach in two phases: before and after 2015.

By 2015:

- Establishment of two additional RDDs in the provinces with the highest mortality rate and where the need for them is greatest. These two RDDs will help public and private partners to re-stock within the health sector's regulatory pathway.

- Signature of a public-private partnership/MOU with at least one local manufacturer based on the following expectations:

* Expectations of the public sector: facilitate the relationship with the technical and financial partners to support the investment required to renovate the infrastructure and build the necessary capacity. Advocacy as well as policy and technical support to start the process of achieving GMP and to facilitate the first activities in the business plan.

* Expectations of the local manufacturer(s): Agreement that the public sector will use the manufacturers' distribution system to distribute ORS/zinc, Cotrimoxazole/dispersible Amoxicillin and ACTs for a set period of time. Accept to participate in the pre-packaging of ORS/zinc packets (see Intervention 6).

After 2015:

- At least one manufacturer with GMP status that produces first-rate ORS/zinc, Cotrimoxazole and/or dispersible Amoxicillin and/or ACTs locally and competes for large procurement contracts.

A technical partner will be needed to take the lead in this intervention with the DPM and the NEMSP, in addition to support from Directorate 5, especially given that there is much to be learned and implemented before getting started. The EMI consortium, with CHAI taking the lead, is also looking to establish relationships from among the regional manufacturers such as ZENUFA and Shelys, to promote cost-effective procurement within the region, and therefore, this intervention can also combine its efforts with those of the regional initiative.

Activities and Main Deliverables:

By 2015:

RDD

- (a) The GDRC will identify buildings to renovate to become RDDs.
- (b) Renovation, equipment and operationalization of the RDD sites.
- (c) Identification of the members of the two RDDs, and capacity building for them.

Local manufacturing

- (a) Organize advocacy workshops with the manufacturers involved, the MoH, the funding bodies and the IPF (Industry Promotion Fund of the DRC).
- (b) Audit of high-performing local manufacturers with respect to the local production of ORS/zinc, dispersible Amoxicillin/Cotrimoxazole and ACTs.
- (c) Business plans with high-performance local manufacturers and with branches in the region, such as ZENUFA, that describe clear expectations as to the potential for each of the three drugs, in terms of the market size, potential for growth and profit and international donor regulations.
- (d) Identify viable plans and sign a public-private partnership/MOU with at least one local manufacturer.
- (e) Facilitate relationships between the manufacturer(s) and the banks as well as the technical and financial partners for investment in the necessary infrastructure renovations and the necessary capacity building.
- (f) Advocacy as well as policy and technical support to start the process to achieve GMP and to facilitate the first activities in the business plan.

- (g) Use of the manufacturer's distribution system, as needed, to facilitate the distribution of ORS/zinc, Cotrimoxazole/dispersible Amoxicillin and ACTs for a set period of time.
- (h) Manufacturer participation in the pre-packaging of ORS/zinc packets (see Intervention 6).
- (i) Official launch to promote the transition.

After 2015

Continue to facilitate relationships between the manufacturer(s) and the banks, as well as the technical and financial partners, for investment in the necessary infrastructure renovations and capacity building. Advocacy and policy and technical support to start the process to achieve GMP and facilitate the first activities in the business plan.

- (a) Support at least one local manufacturer in achieving GMP status.

6. De-medicalize ORS/zinc and ensure its universal coverage

Rationale: Currently, ORS and zinc are « médicaments éthiques » in the DRC and, consequently, can only be distributed in the private or public health sector (pharmacies, clinics and health centers). Their status makes it difficult to access them and yet, given that they consist of only mineral salts and sugar (easy for anyone to handle and with almost no negative side-effects) and given the prevalence, incidence and severity of diarrhea, they should be readily available to the caregivers of children at all times. The de-medicalization of ORS and zinc in other countries, such as Benin, has helped to break down this barrier in those countries and has led to increased accessibility of this health product. A de-medicalization approach will help promote universal coverage of ORS/zinc in the DRC.

Approach: This intervention features a two-pronged approach: a policy response and an implementation response. The change in policy to de-medicalize ORS/zinc must take priority before the focus can shift to social marketing of a pre-packaged product.

At the policy level, the DPM and the National Essential Medicines Supply Program (NEMSP) will take the lead, with support from Directorates 5 and 10. A technical partner will be needed to support the social marketing implementation process in the beginning and to strengthen the capacity of the MoH to continue the process post-2015.

Activities and Main Deliverables:

- (a) Study visit to share experiences from countries with experience (Benin, for example).
- (b) Policy and standard changes to de-medicalize ORS and zinc, and approve their pre-packaging.
 - a. Workshop to prepare the application for the de-medicalization of ORS and zinc.
 - b. Approval of the application and ministerial decree.
- (c) Business plan with a local manufacturer (in principle, the same one identified for Intervention 5) for the pre-packaging (and local production, if approval has been obtained).
- (d) Create innovative distribution systems for ORS and zinc as well as water purifiers (breweries, mobile vendors, kiosks, markets, etc.)
- (e) Social marketing of a pre-packaged kit containing ORS and zinc targeting vulnerable populations in urban areas in all provinces, including Kinshasa.

7. Comprehensive Behavior Change Communications Campaign

Rationale: As explained in section 2.2, there are many access and rational treatment barriers related to knowledge, beliefs and caregiver and care provider outcome expectations. As cited in the *Integrated Health Project in the Democratic Republic of the Congo, Baseline Survey, May 2011*, "Knowledge of danger signs of childhood diseases is poor among mothers of young children. Less than half of mothers of children 0-23 months (44%) know at least one symptom that would trigger them to take the child immediately to a health facility, and very few mothers (8%) are aware of two danger signs of pneumonia. This will require an aggressive and targeted behavior change and communications campaign with simple messages to increase ability to recognize danger signs of childhood diseases and proper care-seeking behaviors through formal information sources of information about health and nutrition ^{22, pg.97}." In terms of care providers, there is a

need to focus on the behaviors related to irrational treatment, and on promoting buy-in and ownership of the community approach and the private sector approach so that these sectors are seen as a complement to the health system and not as competition. Experience has shown that a communications campaign that is segmented in order to focus on decision-makers among technocrats, care providers and academics can help, but only if the intermediate level is involved from the start in launching the initiative and passing communications down to the peripheral levels.

Approach: Based on the experience of ASF/PSI in the DRC, and that of PSI at the global level, the communications campaign will segment the population and use different approaches at different levels. For the caregiver/household decision-makers, contracted community structures will use interpersonal communication techniques, taking advantage of natural caregiver and community congregation points (homes, schools, churches, business, etc.), in order to ensure behavior change communications that are « plus adaptée, plus simple et moins coûteuse ^{11, pg.7}. »⁴⁹ In the DRC, there are active community structures that have a lot of influence, such as the CoCoDev, associations for mother farmers, mother-daughter associations, local NGOs, local churches, and the Promotional Relays (community mobilizers). Intervention 7 will focus on strengthening the capacity of these entities to reach the population. According to the USAID/BASICS experience in 2008, « En l'espace de deux mois, plus 1.000 fidèles des églises ont pu sensibiliser de plus de 14.000 de leurs voisins dans les deux aires de santé. Les résultats de la première enquête LQAS...ont montré que la proportion des mères qui connaissent au moins 2 signes de danger est passée de 25% à 84% entre Mai et Juillet 2008 ^{11, pg.46}. »⁵⁰ But there was, however, a stumbling block: the documentation indicates that this approach has « faible couverture en canaux de communication ^{11, pg. 48}. »⁵¹ For that caregiver/household segment, therefore, medium-level media and mass media will be provided by the Ambassadors for Change approach. The Malaria No More experience in Senegal with the *Surround Sound: Senegal* campaign "activates key sectors of Senegalese society—including entertainment, sport, faith, local business and government—to encourage people to use mosquito nets, to recognize malaria symptoms and to seek treatment ^{23, pg. 15}." Inspired by this experience, a high-visibility mass-media campaign will be implemented by the Ambassadors for Change.

As for the technocrats (CMOs, framework teams, etc.), care providers and academics, the approach will focus on promoting Strategy ownership and buy-in. Under the current system, the intermediate level (the districts and provinces), should provide "technical support" for health activities in the HZs, but the challenge is that the intermediate level is often left-out of initial activity design and implementation and so the sense of ownership and buy-in is low ¹¹. Using PSI/Tanzania's experience as inspiration, Intervention 7 will include a launch campaign to introduce the strategy at the district level with the Chief Medical Officer for the province/district as guest of honor. S/he will explain the importance of the strategy and these interventions. The idea is that the technical managers, technocrats and important care providers will be present at the launch, and then they can pass along the message about the importance of cooperating and supporting the strategy in their district. Secondly, the health hut experience in Senegal has shown that site visits from technical managers and care providers is important in terms of convincing these technicians and officials that community health agents are competent and health huts are effective when it comes to health care delivery. The visits have helped them to believe in and take ownership over the approach, both of which are necessary for the long-term sustainability of the community approach. Building-off of the Senegal experience, the DRC will introduce visits to Community Health Care Sites as an activity to help promote technical manager, care provider and academic buy-in and ownership.

Directorate 5 will take the lead and will contract with technical partners who are experts in the area of BCC (Behavior Change Communications) to develop the campaigns and identify partners to implement them at the community level. The technical partners will strengthen the capacity of the community structures and the national BCC program, and will design the communications campaigns.

⁴⁹ Translation: "better adapted, simpler and less expensive."

⁵⁰ Translation: "In the space of two months, more than 1000 church-goers were able to raise the awareness of 14,000 neighbors in two health areas. The results of the first LQAS survey ...show that the percentage of mothers who were aware of at least two danger signs went from 25% to 84% between May and July of 2008."

⁵¹ Translation: "low communication channel coverage."

Activities and Main Deliverables:

Caregivers:

- (a) Community structures organized within the HZ.
 - Identify 130 community structures (2 per district) and organize them.
 - 260 representative members (2 per structure) trained in entrepreneurship, BCC and program management.
 - Contract community structures to provide interpersonal communications (small grants).
 - Establish a clear link between the BCC work done by the community structures and the Community Health Care Site agent work. To be done by the Nurse In-charge and/or Community Animator (HZCO)
 - (b) Mass Media: Ambassadors for Change Program
 - Identify stars/celebrities, religious and political leaders, journalists, etc. to act as ambassadors.
 - High-visibility mass-media campaign carried-out by the ambassadors (i.e. song competitions, etc.)
- Technical managers, technocrats, care providers and academics
- (c) BCC campaign to promote buy-in to the private and community approaches
 - Visits to Community Health Care Sites and model private structures.
 - Campaign launch at the district level with the Chief Medical Officer of the province/district as guest of honor.

4. WORK PLAN AND BUDGET
4.1 Work Plan (Main Deliverables)

Key interventions	1 st year				2 nd year				3 rd year				4 th year			
	Q1	Q2	Q3	Q4												
Integrate the 3 national programs (NMCP, NARICP and NDDCP) under the leadership of Directorate 5 (to be confirmed)																
Ministerial decree			x													
Identification, training and placement of focal points				x	x	x										
Develop a motivation system						x	x									
Identify or establish "model" HZs in the public sector																
Identify one model HZ per district							x	x								
Training of trainers									x							
Training for HCs										x						
Establish an accreditation program to regulate the private sector																
Identify eligible private facilities (2-4 per district)									x							
Training for private facilities (linked with the training for 15-20 HCs per district)										x						
Extend Community Health Care Site coverage under the responsibility of the HCs																
Identify 5 Community Health Care Sites per HZ									x	x						
Training for site agents to be provided by trained NICs and HCs											x	x				
Introduce cStock in some HZs													x	x	x	x
Promote the drug distribution system and local manufacturing of EMI drugs (by 2015)																
2 new RDDs operational									x	x	x	x	x	x	x	x
Sign an MOU/PPP with at least 1 local manufacturer									x							

De-medicalize ORS/zinc and ensure its universal coverage																
Application approval and Ministerial decree signed (consideration same time as Intervention 1)			x													
Business plan with a local manufacturer for ORS/zinc pre-packaging (perhaps local production)				x	x											
Identification and distribution via innovative channels, including at HZs and Community Health Care Sites. Social Marketing								x	x	x	x	x	x	x	x	x
Comprehensive Behavior Change Communications Campaign																
Identify 2 community structures per district							x									
Training for community structure representatives									x	x						
Interpersonal communications implemented by the community structures											x	x	x	x	x	x
High-visibility mass-media campaign								x	x	x	x	x	x	x	x	x
Campaign launch at the district level with the CMO for the province/district								x	x							
Visits to Community Health Care Sites and model private facilities										x	x	x	x	x	x	x



4.2 Summary Budget, USD (no commodities)

DRC EMI Budget Summary (no commodities)								
	2012	2013	2014	2015	Total 2012-2015	Contribution	Gap	% of the Gap
Integrate the 3 national programs (NMCP, NARICP and NDDCP) under the leadership of the 5th Directorate (to be confirmed)	\$2,421,301	\$3,739,009	\$3,838,285	\$3,917,374	\$13,915,968	\$3,559,299	\$10,356,668	10%
Activity 1.1: Advocacy to obtain a ministerial decree to integrate the 3 NPs under the leadership of the 5th Directorate	\$117,354	\$22,248	\$0	\$0	\$139,602	\$0	\$139,602	
Activity 1.2: Identify, train and appoint the national, provincial and HZ focal points	\$2,152,449	\$3,521,419	\$3,625,698	\$3,727,445	\$13,027,011	\$3,559,299	\$9,467,712	
Activity 1.3: Finalize and formalize the IMCI management document	\$16,510	\$0	\$0	\$0	\$16,510	\$0	\$16,510	
Activity 1.4: Disseminate the IMCI management document using the focal point structure	\$0	\$0	\$29,811	\$3,387	\$33,199	\$0	\$33,199	
Activity 1.5: Analyze DRC's experience with health financial incentives (forfaits, mutual Technical and Managerial Assistance for Activity 1	\$19,688	\$17,294	\$0	\$0	\$36,982	\$36,982	\$36,982	
	\$115,300	\$178,048	\$182,775	\$186,542	\$662,665	\$662,665	\$662,665	
Intervention 2: Identify or establish "model" HZs in the public sector (Public Sector)	\$49,850	\$47,882,053	\$22,455,427	\$21,647,443	\$92,034,773	\$39,622,061	\$52,412,712	50%
Activity 2.1: Identify and reinforce the structures in the model HZ	\$46,539	\$45,429,180	\$17,929,210	\$18,467,086	\$81,872,015	\$37,735,296	\$44,136,719	
Activity 2.2: Train the structures in IMCI	\$0	\$0	\$1,525,466	\$0	\$1,525,466	\$0	\$1,525,466	
Activity 2.3: Provide coaching/supervision for the selected structures	\$0	\$159,901	\$1,931,445	\$2,149,526	\$4,240,871	\$0	\$4,240,871	
Activity 2.4: Organize monitoring of IMCI activities	\$0	\$12,875	\$0	\$0	\$12,875	\$0	\$12,875	
Technical and Managerial Assistance for Activity 2	\$3,311	\$2,280,098	\$1,069,306	\$1,030,831	\$4,383,546	\$1,886,765	\$2,496,781	
Intervention 3: Establish an accreditation program to regulate the private sector (Private Sector)	\$2,275	\$1,335,375	\$371,157	\$114,114	\$1,822,921	\$579,783	\$1,243,138	1%
Activity 3.1: Meetings/workshops to present the results/lessons learned from the MSH/SPS and MoH IMCI Private (Pharmaceutical) Sector pilot project and to discuss an appropriate scale-up approach	\$2,166	\$669,500	\$0	\$0	\$671,666	\$334,750	\$336,916	
Activity 3.2: Hold advocacy meetings with key members of the private sector, including microfinance banks, in order to clarify mutual interests, the incentives that would be of interest to them and a viable approach	\$0	\$540,616	\$0	\$0	\$540,616	\$0	\$540,616	
Activity 3.3: Identify the private structures to be selected	\$0	\$61,670	\$72,406	\$0	\$134,076	\$67,038	\$67,038	
Activity 3.4: Provide training for the private structures in IMCI	\$0	\$0	\$157,976	\$0	\$157,976	\$78,988	\$78,988	
Activity 3.5: Coach/supervise the private structures	\$0	\$0	\$123,101	\$108,680	\$231,781	\$71,398	\$160,382	
Technical and Managerial Assistance for Activity 3	\$108	\$63,589	\$17,674	\$5,434	\$86,806	\$27,609	\$59,197	
Intervention 4: Extend the Community Health Care Site coverage under the responsibility of the HC (Community)	\$0	\$2,107	\$2,830,519	\$1,007,959	\$3,840,585	\$0	\$3,840,585	4%
Activity 4.1: Map and analyze the Community Health Care Site situation	\$0	\$2,007	\$3,777	\$0	\$5,784	\$0	\$5,784	
Activity 4.2: Identify 1175 CHCS in the 5 provinces with the highest mortality rates	\$0	\$0	\$1,791,818	\$0	\$1,791,818	\$0	\$1,791,818	
Activity 4.3: Train 3 CHCS agents per Community Health Care Sites	\$0	\$0	\$900,138	\$0	\$900,138	\$0	\$900,138	
Activity 4.4: HC coaching/supervision of the Community Health Care Sites	\$0	\$0	\$0	\$625,626	\$625,626	\$0	\$625,626	
Activity 4.5: Strengthen motivation (monetary and non-monetary)	\$0	\$0	\$0	\$144,188	\$144,188	\$0	\$144,188	
Activity 4.6: Introduce cstock	\$0	\$0	\$0	\$190,147	\$190,147	\$0	\$190,147	
Technical and Managerial Assistance for Activity 4	\$0	\$100	\$134,787	\$47,998	\$182,885	\$0	\$182,885	
Intervention 5: Promote the drug distribution system and local production of EMI drugs	\$0	\$3,058,156	\$220,987	\$34,512	\$3,313,655	\$525,000	\$2,788,655	3%
Activity 5.1: Organize workshops with different stakeholders	\$0	\$78,865	\$0	\$0	\$78,865	\$0	\$78,865	
Activity 5.2: Organize the audit of pre-selected local manufacturers	\$0	\$134,003	\$0	\$0	\$134,003	\$0	\$134,003	
Activity 5.3: Develop business plans with the most productive local manufacturers	\$0	\$21,661	\$0	\$0	\$21,661	\$0	\$21,661	
Activity 5.4: Identify viable plans and sign an MOU/public-private partnership with at least one local manufacturer	\$0	\$0	\$35,942	\$24,760	\$60,702	\$0	\$60,702	
Activity 5.5: Initiate local production	\$0	\$0	\$0	\$8,108	\$8,108	\$0	\$8,108	
Activity 5.6: Use the manufacturer's distribution network, as necessary, to facilitate the distribution of ORS/zinc, Cotrimoxazole/Amoxycillin and ACTs for a set period of time	\$0	\$0	\$174,522	\$0	\$174,522	\$0	\$174,522	
Activity 5.7: Strengthen the NEMSS	\$0	\$2,678,000	\$0	\$0	\$2,678,000	\$500,000	\$2,178,000	
Technical and Managerial Assistance for Activity 5	\$0	\$145,626	\$10,523	\$1,643	\$157,793	\$25,000	\$132,793	
Intervention 6: De-medicalize ORS/zinc and ensure its universal coverage	\$47,946	\$399,181	\$5,107,952	\$5,513,022	\$11,068,100	\$1,088,578	\$9,979,522	10%
Activity 6.1: Advocacy to change the policies and standards to demedicalize ORS and zinc	\$45,663	\$0	\$0	\$0	\$45,663	\$2,000	\$43,663	
Activity 6.2: Support for a business plan with a local manufacturer to pre-package an ORS-Zinc kit (see the firms selected)	\$0	\$273,227	\$339,761	\$451,000	\$1,063,987	\$1,034,741	\$29,246	
Activity 6.3: Establish innovative distribution channels for ORS and zinc as well as water purifiers (brewers, mobile vendors, kiosks, markets, etc.)	\$0	\$92,247	\$7,988	\$3,303	\$103,538	\$0	\$103,538	
Activity 6.4: Social marketing of pre-packaged ORS/zinc in urban and semi-urban areas	\$0	\$14,698	\$4,516,967	\$4,796,195	\$9,327,860	\$0	\$9,327,860	
Technical and Managerial Assistance for Activity 6	\$2,283	\$19,009	\$243,236	\$262,525	\$527,052	\$51,837	\$475,215	
Intervention 7: Comprehensive Behavior Change Communications campaign	\$0	\$1,794,050	\$1,788,841	\$1,701,565	\$5,284,456	\$0	\$5,284,456	5%
Activity 7.1: Identify 130 community structures (NGOs, mothers' groups, etc.), or 2 per health district	\$0	\$20,426	\$0	\$0	\$20,426	\$0	\$20,426	
Activity 7.2: Provide training for 260 community structure representatives in project management, IMCI (2 per health structure)	\$0	\$0	\$130,320	\$0	\$130,320	\$0	\$130,320	
Activity 7.3: Contract structures to conduct IPC (small grants)	\$0	\$0	\$248,251	\$255,698	\$503,949	\$0	\$503,949	
Activity 7.4: Identify the Ambassadors for Change to conduct mass media campaign	\$0	\$1,286,493	\$1,325,087	\$1,364,840	\$3,976,420	\$0	\$3,976,420	
Activity 7.5: Organize BCC campaigns to promote ownership of private and community approaches by technical managers, care providers and academics	\$0	\$401,700	\$0	\$0	\$401,700	\$0	\$401,700	
Technical Assistance for Activity 7	\$0	\$85,431	\$85,183	\$81,027	\$251,641	\$0	\$251,641	
Evaluation and Research (not including regular coaching/supervision)	\$122,476	\$227,937	\$106,090	\$2,862	\$459,364	\$0	\$459,364	0.44%
Support for the preparation of the 2012 DHS: integration of child survival indicators	\$110,476	\$0	\$0	\$0	\$110,476	\$0	\$110,476	
Organize promotional material focus group discussions (may integrate into Interv #7)	\$12,000	\$0	\$0	\$0	\$12,000	\$0	\$12,000	
Support for organizing the MICS in 2015 to evaluate the interventions	\$0	\$0	\$106,090	\$2,862	\$108,952	\$0	\$108,952	
Regular LQAS (please see section 5 on monitoring and evaluation)	\$0	\$227,937	\$0	\$0	\$227,937	\$0	\$227,937	
Coordination	\$644,443	\$11,788,342	\$7,447,643	\$6,894,676	\$26,775,104	\$9,074,944	\$17,700,160	17%
Organize 2 workshops per year to coordinate with other child survival initiatives and stakeholders	\$5,040	\$5,191	\$5,347	\$5,507	\$21,084	\$0	\$21,084	
Share experiences with the other EMI countries	\$38,076	\$39,218	\$40,395	\$41,607	\$159,296	\$0	\$159,296	
Organize advocacy meetings to present/share results with donors and members of the consortium in the USA and Geneva	\$53,520	\$36,750	\$37,853	\$38,988	\$167,112	\$0	\$167,112	
Hold an annual international meeting with the consortium	\$19,038	\$19,609	\$20,197	\$20,803	\$79,648	\$0	\$79,648	
Coordination/Administration Fee	\$528,769	\$11,687,574	\$7,343,852	\$6,787,770	\$26,347,965	\$9,074,944	\$17,273,020	
Grand Total	\$3,288,290	\$70,226,210	\$44,166,901	\$40,833,525	\$158,514,927	\$54,449,666	\$104,065,261	100%

5. IMPLEMENTATION ORGANIZATION

5.1 Monitoring and Evaluation

The monitoring and evaluation process will promote participatory collection, analysis and utilization of data. The comprehensive monitoring and evaluation structure will 1) plot progress in meeting workplan deliverables and service use, 2) measure the quality of intervention implementation and coverage, and 3) identify stumbling blocks to achieving the objectives. The data for the main deliverables and specific outcomes will be collected from monitoring reports, Health District performance reviews, service statistics from public and private health facilities and from site data.

To reduce the cost normally associated with the collection and analysis of changes in knowledge, attitudes and practices, *Lot Quality Assurance Sampling* (LQAS) survey methods will be used, where appropriate. The DRC already has a significant amount of experience with this method and uses it in its community approach¹¹. The method usually relies on Management Team members to collect data as part of their normal supervision and support activities¹¹. The strategy calls for providing LQAS training to at least 2-4 members of the targeted HZ Management Teams in order to increase the list of eligible trained LQAS members who have also already attended IMCI training.

In terms of the outcome indicators, the data will be gathered during the MOH surveys already planned to measure NHDMP results and/or during national surveys such as the DHS and the MICS. The 2012 DHS will be considered as the baseline study and the 2015 MICS will be the final evaluation study.

Data analysis and approach modification decisions will be made initially at the peripheral level during post-training follow-up meetings with the Site agents and regular meetings with the HZ care providers. The GRH/ZMT trainer will be responsible for compiling the analyses and comments from the meetings into a report. These HZ reports will be grouped together at the district level during the performance review of the Health District, and the district focal point will be responsible for compiling the ideas and recommendations that result from these reviews. The provincial/central reviews will also be compiled, based on the format suggested by the provincial focal point. The national focal point will be responsible for compiling the data and recommendations into a final report to be sent to the MoH Secretary-General. At each level, the official responsible for compiling the data will also be responsible for disseminating the recommendations to the next level down in the structure via meetings and routine supervision visits conducted by him/herself or members of his/her team.

5.2 Risk Assessment

The strategy developed in this document is intended to contribute to the goal of universal coverage of ORS/zinc, ACTs and dispersible Amoxicillin/Cotrimoxazole, but it is not a global strategy like the SRSS. It contributes to the goals of the SRSS and the NHDMP, as well as the goal of universal coverage, with the expectation that the MOH, the technical and financial partners, as well as the private sector, will continue to work on the other gaps and health system challenges not covered by this strategy but linked to the Strategy's goal. The Strategy, therefore, makes certain assumptions regarding risks and the current situation. This section provides a summary of these critical assumptions and risks and proposes responses to the risks.

Critical Assumptions:

- Stability within the country;
- The GDRC will place priority on implementing the SRSS and the NHDMP, strengthening health human resources, strengthening the NEMSS and drug regulation, and increasing the health budget to 10-15% of the annual GDRC budget;
- The GDRC will provide strategy leadership and coordination, and will promote sustainability, with a special emphasis on partner coordination;
- Financial partners are ready to support the GDRC in achieving the Strategy objectives;
- The GDRC is committed to good governance, accountability and transparent practices.

Significant Risks:

- Cross-disease risks:
 - This strategy is not a stand-alone approach that can alone ensure universal coverage.
 - Response: The SRSS, which already exists, describes the overall long-term strategy. This strategy complements the SRSS with interventions that are effective and can be achieved by 2015. Continued funding and focus on the SRSS and other domains is necessary to move towards achieving the goal of universal coverage in all three treatments.
 - Procurement outside the regulated network and reliance on products of questionable quality
 - Response: increase the number of quality points of sale (Intervention No. 3 and social marketing), use of local manufacturer distribution networks, and increase in the number of RDDs in the country (this strategy supports 2 RDDs, and other partners are supporting others).
 - Limited drug regulation authority
 - Response:
 - Include the DPM and capacity building for the DPM in the strategy.
 - Support and coordinate links with other partners who are working to improve drug regulation.
 - Limited support to remote zones, poor communities and vulnerable populations outside the 5 targeted provinces.
 - Response: The task force tried to choose provinces with the highest child mortality rates based on their analysis of the current Community Health Care Site mapping situation. Under Intervention No. 4, the strategy calls for exhaustive mapping and identification of the situation at the Community Health Care Sites to confirm or change the sites selected for intervention. Furthermore, other partners should simultaneously support other provinces.
 - Length of time required to implement the interventions, especially Intervention No. 1 and the identification and implementation of the focal points. The change in policy and the implementation of the coordination structure under Intervention 1 is the basis for the other interventions.
 - Response: The action plan has allocated up to one year for the initial policy change and focal point structure establishment linked to Intervention 1, and the MoH has already begun the process.
 - Limited focus on non-model HZs
 - By putting in place one model HZ per district, the initiative offers a model on which the Health District can base improvements to the other HZs, in accordance with the NHDMP, which will take the lead.
 - Frequent medicine stock-outs: problem related to supply chain management (NEMSS)
 - Response: coordination and links with the other partners who are working to strengthen the NEMSS, use of local manufacturer distribution networks, and initiation of cStock, etc.
 - Most of the population cannot afford the needed drugs and health services
 - Response:
 - Analyze experiences with financial incentives, mutual health insurance, community funds, etc. and implement a plan for health funding (Intervention No. 1).
 - Drug subsidies from the government and partners
 - Contribute to the NHDMP Strategy No. 3, R1: « La part du budget de la Sante augmente chaque année pour atteindre 15% du budget national d'ici 2015, son taux d'exécution augmente et la pertinence de l'affectation du budget de l'Etat consacré à la sante s'améliore. »⁵²
 - Creation of parallel data management systems, especially at the community level.
 - Response: coordination and links with the other partners who are working to strengthen the HMIS and the c-HMIS.

⁵² Translation: "The Health budget increases annually to reach 15% of the national budget by 2015, with improvements in its implementation rate and in the effectiveness of government funds allocated to health."

- Irregular salary payments for care providers and lack of motivation
 - Response: analyze experiences with financial incentives, mutual health insurance, community funds, etc. (Intervention No. 1).
- Diarrhea:
 - Limited demand for zinc and ORS
 - Response: Intervention No. 7 with a segmented approach that specifically targets caregivers/household decision-makers.
 - Price of zinc and ORS
 - Response: drug subsidies from the government and partners
 - Contribute to the NHDMP Strategy No. 3, R1: « La part du budget de la Sante augmente chaque année pour atteindre 15% du budget national d'ici 2015, son taux d'exécution augmente et la pertinence de l'affectation du budget de l'Etat consacré à la sante s'améliore. »⁵³
 - Prescriptions for zinc and ORS in addition to antibiotics that should not be prescribed
 - Response: Care provider training & supervision, in addition to care provider targeted BCC.
 - Pre-packaging ORS/zinc may promote irrational use of zinc (use for <10 days) given that the recommended timing for ORS use is shorter
 - Response: Intervention No. 7 with a segmented approach that specifically targets caregivers/household decision-makers.
- Malaria:
 - Prescription for ACT and antibiotics for a negative RDT, instead of replacing the ACT
 - Response:
 - Action plan to finalize the IMCI management document and full dissemination of that document.
 - Care provider training & supervision, in addition to care provider targeted BCC.
 - High price of ACT
 - Response: drug subsidies from the government and partners
 - Contribute to the NHDMP Strategy No. 3, R1: « La part du budget de la Sante augmente chaque année pour atteindre 15% du budget national d'ici 2015, son taux d'exécution augmente et la pertinence de l'affectation du budget de l'Etat consacré à la sante s'améliore. »⁵⁴
 - Malaria efforts and success decrease with the integration of the NMCP
 - Response:
 - Encourage the technical and financial partners to move their funds specifically earmarked for malaria and the NMCP to Child Survival in general and Directorate 5 in particular.
 - Continuing support for the NMCP Strategic Plan from other partners, such as PMI.
- Pneumonia:
 - Lack of oxygen availability at the referral level
 - Response:
 - Oxygen is part of the complete package that will be made available at the GRFs in the model HZs.
 - The NHDMP will take the lead in ensuring that the other HZs have complete packages.
 - High price of antibiotics
 - Response: drug subsidies from the government and partners
 - Contribute to the NHDMP Strategy No. 3, R1: « La part du budget de la Sante augmente chaque année pour atteindre 15% du budget national d'ici 2015, son taux d'exécution augmente et la pertinence

⁵³ Translation: same as #52 above

⁵⁴ Translation: same as #52 above

de l'affectation du budget de l'Etat consacré à la sante s'améliore. »⁵⁵

- Not enough focus on pneumonia
 - Response: Increased focus on IMCI and an integrated approach across the private and public sectors and the community level will help highlight specific pneumonia bottlenecks. Effective solutions will be identified and integrated into the Strategy.

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⁵⁵ Translation: "The Health budget increases annually to reach 15% of the national budget by 2015, with improvements in its implementation rate and in the effectiveness of government funds allocated to health"

REFERENCES

Key informant interviews were used as a major source of data collection. A literature review was also conducted. More than 20 interviews were arranged with stakeholders in the public sector, the private sector and at the community levels. Multiple documents (national surveys, project documents and reports, national and sector-based policy documents, standards and directives, national strategy documents, case studies, etc.) were consulted. A task force was coordinated by the MoH with support from ASF/PSI, and the task force was an additional important source of information. The task force, which was made up of about twenty GDRC experts, partners and financial partners (MOH Secretary-General, NDDCP, NARICP, NMCP, NEMSP, DEP, Directorate 3, Directorate 5, Directorate 10, past COP of MCHIP, WHO, UNICEF, USAID, MSH and FEDECAME), supplemented the information previously gathered by the consultant during two workshop that together covered seven days. The Strategy outlined in this document is the outcome of the analysis of the interviews and the literature review conducted by the task force with the consultant. Literature review sources are numbered and cited throughout in ^{superscript} and the numbers correspond to the numbered list below. Direct French quotation translations are numbered and marked throughout in _{subscript}.

- 1) USAID (2010). Request for Application (RFA) No. USAID RFA-OAA-10-000006, USAID/Democratic Republic of the Congo. *Integrated Health Project (IHP)*
- 2) Opetha PL (2011). Revue Annuelle 2010 : évolution de l'état de santé de la population congolaise [Power Point slides].
- 3) République Démocratique du Congo, Ministère de la Santé Publique, Secrétariat General (2010). Stratégie de Renforcement du Système de Santé, deuxième édition.
- 4) République Démocratique du Congo, Ministère de la Santé Publique (2010). Plan National de Développement Sanitaire, PNDS 2011-2015.
- 5) Measure DHS. République Démocratique du Congo Enquête Démographique et de Santé, EDS-RDC (2007). <http://www.measuredhs.com/pubs/pdf/FR208/FR208.pdf> (October 1, 2011)
- 6) MICS (2010). Democratic Republic of the Congo Multiple Indicators Cluster Survey MICS – 2010, Preliminary Findings.
- 7) OMS (2010). Statistiques Sanitaires Mondiales 2010. Mortalité par cause spécifique et morbidité, Tableau distribution des causes de décès parmi les enfants de moins de 5 ans 2008. http://www.who.int/whosis/whostat/FR_WHS10_Full.pdf (November 1, 2011).
- 8) République Démocratique du Congo Ministère de la Santé Publique (2008). Déclaration de Politique Nationale de Lutte Contre les Maladies Diarrhéiques.
- 9) ACTwatch Group. Household Survey Report, DRC, 2010 Survey. www.actwatch.info
- 10) USAID/République Démocratique du Congo. USAID/RDC Infos (Septembre 2010). http://www.usaid.gov/locations/sub-saharan_africa/countries/drcongo/newsletters/drc_newsletter_fr0910.pdf (December 2, 2010)
- 11) MCHIP, PSI, OMS, Save the Children pour République Démocratique du Congo Ministère de la Santé Publique. Prise en Charge Communautaire Intégrée des Maladies de l'Enfant: Documentation des Meilleures Pratiques et des Goulots d'Etranglement à la mise en œuvre du programme en RDC (2011).
- 12) Le Secteur de la Santé en RDC. http://www.beltrade-congo.be/documents/PMPTR_sante.pdf (December 2, 2011)
- 13) WHO et République Démocratique du Congo Ministère de la Santé Publique Secrétariat Général, Programme National d'Approvisionnement en Médicament (2010). Cartographie des Systèmes d'Approvisionnement et de Distribution des Médicaments et Autres Produits de Santé en RDC.
- 14) République Démocratique du Congo Ministère de la Santé Publique, Programme National de Lutte Contre le Paludisme (2007). Faire Reculer le Paludisme, Plan Stratégique 2007-2011.
- 15) République Démocratique du Congo (2006). Document de la Stratégie de Croissance et de Réduction de la Pauvreté (DSCRCP).

- 16) République Démocratique du Congo, Ministère de la Santé Publique, Secrétariat General (2008). Programme National de Lutte Contre les Maladies Diarrhéiques, Normes et Directives Nationales.
- 17) Fixsen DL, Blase KA, Duda MA, et al. Implementation of Evidence-Based Treatments for Children and Adolescents (2010). Reprinted from: Evidence-Based Psychotherapies for Children and Adolescents, 2nd Edition, edited by John R. Weisz, and Alan E. Kazdin; Copyright 2010 by the Guilford Press, 72 Spring Street, New York, NY 10012. 435-450.
- 18) Rutta E, Senauer K, Johnson K, Adeya G. Creating a new class of pharmaceutical services provider for underserved areas: the Tanzania Accredited Drug Dispensing Outlet experience (2009). *Progress in Community Health Partnerships: Research, Education, and Action*; **3**(2): 145-153.
- 19) Mbumba Kinsaku, B., G. Bukasa, et S. Diarra. 2009. Connaissances et pratiques du personnel des pharmacies privées sur la prise en charge des maladies de l'enfant dans deux zones de santé de la Ville-Province de Kinshasa, République Démocratique du Congo, août 2009 : Rapport des résultats d'enquête. Présenté à l'Agence des États-Unis pour le Développement International par le Programme Strengthening Pharmaceutical Systems (SPS). Arlington, VA: Management Sciences for Health.
- 20) CCMCentral: integrated community case management of childhood illness. MCHIP Documentation of mature national iCCM programs; the Case of the Democratic Republic of the Congo. <http://www.ccmcentral.com/?q=node/318> (October 6, 2011).
- 21) JSI. cStock: creating an SMS system to improve supply of child health medicines for CCM in Malawi (2011). Supply Chains 4 Community Case Management (SC4CCM).
- 22) MSH, IRC, OSC Ltd. for USAID, Integrated Health Project in Democratic Republic of the Congo, Baseline Survey, May 2011 (August 2011).
- 23) Malaria No More. Malaria No More Stakeholder Report 2009.

6. APPENDICES

7.1. Detailed Work Plan

Key interventions	Officials and others responsible	1 st year				2 nd year				3 rd year				4 th year			
		Q1	Q2	Q3	Q4												
Integrate the three national programs (NMCP, NARICP, and NDDCP) under the leadership of Directorate 5 (to be confirmed)																	
Study visit to Senegal	Directorates 5 (D5) and 10 (D10), NDDCP, NARICP, NMCP and technical partners		x														
Signature of the Ministerial Decree	Directorates 5 and 10, NDDCP, NARICP, NMCP, with support from technical partners			x													
National Focal Point - Identification, training and placement	D5, National Focal Point and technical partners				x												
District Focal Points - Identification, training and placement	D5, National Focal Point and technical partners				x	x	x										
Finalization and formalization of the IMCI document	Directorates 5 and 10, National Focal Point and technical partners	x	x	x	x												
Dissemination of the IMCI document (1 st by the District Focal Point, then GRHs/HCs and lastly by agents)	National Focal Point, Provincial Focal Points, District Focal Points, GRHs/HCs and Community Health Care Sites					x	x	x	x	x	x	x	x	x	x	x	x
Analyze experiences with incentives, forfaits, mutual health insurance and community funds	Directorates 5 and 10, NDDCP, NARICP and NMCP with partners	x	x	x	x												

Develop a motivation system	D5, Focal Points, and technical partners						x	x										
Identify or establish "model" HZs in the public sector																		
Study the 6 model HZs cited in the SRSS	Directorate 5, National Focal Point, Directorate 10 and technical partners			x	x	x	x											
Identify one model HZ per district	Directorate 5, National Focal Point, Provincial Focal Points and District Focal Points								x	x								
Training of trainers	National Focal Point, Provincial Focal Points, District Focal Points and the pool of trainers already in place										x							
Training for HCs	GRH/ZMT (trained trainers)											x						
Intermediate-level supervision (province and district) by the central level	National Focal Point, Provincial Focal Points, Directorate 5 and technical partners									x		x		x		x		x
Supervision of GRHs	District Focal Points											x	x	x	x	x	x	x
Supervision of HCs	GRH												x	x	x	x	x	x
Establish an accreditation program to regulate the private sector																		
Meetings/workshops to present the MSH/SPS and MoH Private (Pharmaceutical) Sector IMCI pilot results	Directorate 5, DPM, NDDCP, NARICP and NMCP with technical partners			x	x													

Advocacy meetings with the private sector	DPM, Directorate 5, National Focal Point, Provincial Focal Points, District Focal Points and technical partners							x	x										
Create/update the selection examination	DPM, Directorate 5, National Focal Point, District Focal Points and technical partners with SPS							x	x										
Written examination sessions	Provincial/District Focal Points																		
Implementation of "mystery client" visits	Provincial/District Focal Points, trained trainers from GRH/ZMT, technical or other partner																		
Identify eligible private facilities (2-4 per district)	DPM, Directorate 5, National Focal Point, Provincial/District Focal Points and technical partners																		
Complete training for private facilities (linked to the training for the 15 to 20 HCs per district)	GRH/ZMT (same as the HC training)																		
Short-format training (first part of the complete training)	GRH/ ZMT (same as the HC training)																		
Supervision of accredited facilities	District Focal Points																		
Extend Community Health Care Site coverage under the responsibility of the HCs																			
Map and analyze the Community Health Care Site situation. Basic	National Focal Point, Directorates 5 and 10 and																		

renovation of some existing sites, if necessary	technical partners																	
Identify 5 Community Health Care Sites per HZ	National Focal Point with the Directorates 5 and 10, Provincial/District Focal Points and technical partners										x	x						
Training for CHCS agents conducted by NICs at trained HCs	Nurse In-charge from trained HC												x	x				
Supervision for CHCS agents	Nurse In-charge (HC) and Community Animator (HZCO)														x	x	x	x
Introduce cStock in some HZs	Technical partner														x	x	x	x
Promote the drug distribution system and local manufacturing of EMI drugs (by 2015)																		
GDRC provides buildings ready to be renovated as RDDs	NEMSP, DPM, with support from Directorate 5				x													
Renovate 2 RDD sites	NEMSP, FEDECAME and technical partners					x	x	x										
Identify members of 2 RDDs and provide them with capacity-building	NEMSP, FEDECAME, Directorate 5, Focal Points and technical partners								x	x	x							
2 new operational RDDs	NEMSP and FEDECAME										x	x	x	x	x	x	x	x
Advocacy workshop with local manufacturers	DPM, Directorate 5/National Focal Point and technical partners							x	x									
Audit of local manufacturers	DPM, Directorate 5/National Focal Point							x	x									

	and technical partners																	
Business plan developed with local manufacturers	DPM, Directorate 5/National Focal Point and technical partners								x									
Identify viable business plans	DPM, Directorate 5/National Focal Point and technical partners									x								
Sign MOU/PPP with at least one local manufacturer	DPM, Directorate 5/National Focal Point										x							
Facilitate links/relationship between the local manufacturer(s) and the banks and financial partners	DPM, Directorate 5/National Focal Point and technical partners											x	x	x	x	x	x	x
Advocacy, policy work and technical support for the GMP process	DPM, Directorate 5/National Focal Point and technical partners												x	x	x	x	x	x
Use of the manufacturer's distribution system/network	Negotiated by DPM, Directorate 5/National Focal Point and technical partners Use by Provincial and District Focal Points, HZs and CHCS agents													x	x	x	x	x
De-medicalize ORS/zinc and ensure its universal coverage																		
Study visit to other countries with experience (for example, Benin)	DPM, Directorate 5 and technical partners	x	x															
Workshop to prepare the de-medicalization application document	DPM, Directorate 5, NDDCP, NARICP and NMCP with support from technical partners		x															

Application approval and signature or ministerial decree	DPM, Directorate 5/National Focal Point, NDDCP, NARICP and NMCP			x														
Business plan with a local manufacturer for pre-packaging (and perhaps local production)	DPM, Directorate 5 and technical partners				x	x												
Production and pre-packaging	Local manufacturer					x	x	x										
Establish innovative distribution channels for ORS and zinc	NEMSP, Directorate 5, National Focal Point and technical partners				x	x	x	x										
Distribution using innovative channels and distribution to HZs and Community Health Care Sites	NESMP and technical partners								x	x	x	x	x	x	x	x	x	x
Social marketing of pre-packaged kit	Focal Points and technical partners				x	x	x	x	x	x	x	x	x	x	x	x	x	x
Comprehensive Behavior Change Communications Campaign																		
Identify 2 community structures per district	Directorate 5 /National Focal Point, District Focal Point/HZ and technical partners								x									
Training for 2 structure representatives (2 per structure)	District Focal Point/HZ and technical partners									x	x							
Contracts signed with community structures	Directorate 5 /National Focal Point											x						
Interpersonal communications conducted by community structures	Contracted structures											x	x	x	x	x	x	x
Identify Ambassadors for Change	Directorate 5 /National Focal Point, District Focal Point and technical partners						x	x	x									

High-visibility mass-media campaign	Ambassadors for Change and technical partners									x	x	x	x	x	x	x	x	x
Campaign launch at the district level with Provincial/District guest of honor	District Focal Points									x	x							
Visits to Community Health Care Sites and model private structures	Provincial, District and HZ Focal Points											x	x	x	x	x	x	x

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7.2. Detailed Budget

Please see the detailed budget in the attached Excel document.

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7.3. Monitoring and Evaluation Log Frame

Goal and Objectives	Outcome Indicators	Output Indicators	Data source	Data collection methods
DRC General Objective: Reduce the child mortality rate to 66/1,000 by 2015				
General Strategy Objective: Universal coverage of ORS/zinc for diarrhea, ACTs for malaria, and dispersible Amoxicillin/Cotrimoxazole for pneumonia				
Objective 1: Social and policy environment enables (Intervention 1)	<p>*15% increase in the Directorate 5 budget compared to the individuals budgets of the NDDCP, NARICP and NMCP (5% per year over 3 years)</p> <p>Contribution to the NHDMP Strategy 3, R1 « La part du budget de la Santé augmente chaque année pour atteindre 15% du budget national d'ici 2015, son taux d'exécution augmente et la pertinence de l'affectation du budget de l'Etat consacré à la sante s'améliore⁴. »⁵⁶</p> <p>* Reduced fragmentation and increased consistency in Child Survival policy communications and dissemination</p>	<p>* Ministerial decree announces the integration of the three national programs (NDDCP, NARICP and NMCP) and reorganization under the leadership of Directorate 5</p> <p>* 90% of the provinces have a focal point situated under the leadership of Directorate 5</p> <p>* 80% of the health districts have a focal point situated under the leadership of Directorate 5</p> <p>* IMCI management document has been approved</p> <p>* Dissemination of the IMCI management document to all levels targeted by this strategy</p> <p>* A motivation system that has been officially approved for the public sector and the community level</p>	<p>* Register of ministerial decrees</p> <p>* Quarterly district review</p> <p>* Partner reports</p> <p>* National budget</p> <p>* Key informants</p>	<p>* Review</p> <p>* Document Analysis</p> <p>* Interviews</p>

⁵⁶ Translation: "The Health budget increases annually to reach 15% of the national budget by 2015, with improvements in its implementation rate and in the effectiveness of government funds allocated to health"

<p>Objective 2: Access to and availability of quality primary health care services increased (Interventions 2, 3 and 4)</p>	<p>* 80% of care providers (public, private accredited and Community Health Care Site agents) identified under this strategy can correctly diagnose the three illnesses in accordance with IMCI standards (outcome related to Intervention 1, 2, 3 and 4).</p> <p>*80% of care providers (public, private accredited and Community Health Care Site agents) identified under this strategy can correctly explain prevention and rational treatment of the three illnesses in accordance with IMCI (outcome related to Intervention 1, 2, 3 and 4).</p>	<p>* 80% of health districts have a model HZ trained in IMCI that serves as a reference * 60% of the GRHs and 15-20 HCs in the model HZ had no stock-outs in the previous quarter * 70% of the GRHs in the model HZs properly supervised the HCs in their area in the previous quarter * 70% of the HCs in the model HZs of the 5 provinces identified under Intervention 4 properly supervised the Community Health Care Sites in their area in the previous quarter * 50% of facilities in the model HZs use some type of health financial incentive system, forfait, solidarity fund, community health fund, or some other incentive system to motivate their staff members</p> <p>* 80% of the health districts have 2-4 government-accredited private facilities * 60% of accredited private facilities had no stock-outs in the previous quarter * 70% of accredited private facilities had 1 supervision visit per month in the first quarter 70% of accredited private facilities received 1 supervision visit in the previous quarter (after the 1st quarter) * 80% of the HZs in the 5 provinces targeted in Intervention 4 have at least 5 Community Health Care Sites * 60% of the Community Health Care Site agents involved in the cStock pilot project had no stock-outs in the previous quarter * 80% of Community Health Care Site agents targeted by this strategy were monitored once a month in the first quarter. * 70% of Community Health Care Sites targeted by strategy were monitored in the previous quarter (after the first quarter) * 30% of the sites targeted by the strategy use cStock to manage community supplies and motivate agents.</p>	<p>* Quarterly district review * Partner reports * Supervision logbooks * Stock records/HMIS * Training records * Service provision statistics (public and private facilities) * CHCS Data * Key informants</p>	<p>* Review * Document Analysis * Interviews * LQAS</p>
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<p>Objective 3: Access to and availability of quality treatments increased (Interventions 5 and 6)</p>	<ul style="list-style-type: none"> * Drugs are available at all model HZs * 65% universal coverage in ORS/zinc at the national level * 60% of children under the age of five years who have had diarrhea in the two weeks prior to the survey in the intervention zones received ORS/zinc (outcome tied to all the other interventions) 	<ul style="list-style-type: none"> * Implementation and operationalization of 2 new RDDs * Use of a local manufacturer's national distribution system/network to complement the efforts of the NEMSP and the RDDs * Establishment of a PPP between the DRC and at least one local manufacturer * Ministerial decree de-medicalizing ORS/zinc * National distribution of ORS/zinc 	<ul style="list-style-type: none"> * Registry of ministerial decrees * Quarterly district review * Partner reports * Key informants 	<ul style="list-style-type: none"> * Review * document analysis * Interviews * LQAS * DHS, MCIS and other national surveys
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<p>Objective 4: Demand for quality primary health care services and positive behavior increased (Intervention 7)</p>	<ul style="list-style-type: none"> * Increase from 44% to 60% the % of caregivers of children aged 0-23 months who can identify at least one serious symptom of the three diseases that requires early care-seeking ** Increase to 60% the % of caregivers of children under 5 ** Increase to 80% in the intervention zones for caregivers of children aged 0-23 months and 0-5 years * Increase from 8% to 25% the % of caregivers who can identify at least two danger signs of pneumonia ** Increase to 40% in the intervention zones * Increase from x% to y% the % of caregivers who can identify at least two danger signs ** Increase from x% to y% for diarrhea ** Increase from x% to y% for malaria ** Distinction between nationwide and intervention zones ** Effort to identify baselines before setting percentages 	<ul style="list-style-type: none"> * Sign contracts with 130 organized community structures in the targeted HZs * High-visibility mass-media campaign led by the Ambassadors for Change (i.e. song competitions, etc.) * Launch the campaign in each district with the Chief Medical Officer for the province/district as guest of honor * x% of the private facilities and Community Health Care Sites with at least one support activity included in the Health District performance review (baseline % TBD) * (Re)establishment of an "active" budget line at the provincial level to support site activities * The HZs take into account Community Health Care Sites supply needs when placing orders with the HZCO 60% of the time * One semi-annual visit apart from the supervision visits per private facility and organized site 	<ul style="list-style-type: none"> * Quarterly district review * Partner reports * Provincial budget * Stock records/HMIS * Supervision logbooks * Service provision statistics (public and private facilities) * CHCS Data * Key informants 	<ul style="list-style-type: none"> * Review * Document analysis * Interviews * LQAS * DHS, MCIS and other national surveys
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7.4 Results Framework (with selected targets) for EMI in the DRC

