

Global Health Initiative
Democratic Republic of Congo Strategy
2011 – 2014



In Partnership with the Government of DRC

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I. GHI Vision

Building on over three decades of partnership and collaboration between the Governments of the Democratic Republic of the Congo (GDRC) and the United States Government (USG), the four year U.S. Global Health Initiative (GHI) in the Congo represents an opportunity to substantially accelerate DRC's development goals in health. The GHI vision is to ***Improve the Health of the Congolese People*** with a particular focus on the health of the most vulnerable groups (i.e. women, girls, newborns and children under-five), and reducing the communicable diseases causing the highest burden of disease.

Under this vision, GHI will contribute to three of the DRC's Millennium Development Goals (MDGs): the reduction of maternal and under-five child mortality (MDGs 4 & 5) and combating infectious diseases (MDG 6). To strengthen the delivery and utilization of quality healthcare services, USG supported programs in DRC will focus on three cross-cutting areas: ***strengthened human resources for health (HRH), improved supply chain management (SCM) systems, and support to results based financing (RBF)***. The strategy describes how the GDRC and USG will collaborate on intensified interventions under each of the focus areas to accelerate progress towards the MDGs. Both governments acknowledge the immensity and complexity of the country and the need for multiple donors and private sector support to affect national health indicators. Comprehensive primary health care (PHC) interventions will impact health results in identified provinces and health zones (HZs);¹ other activities will be more national in scope.

By increasing the availability, use, and quality of comprehensive primary health care (PHC) and HIV/AIDS services, USG supported programs in DRC will focus on three cross-cutting areas: *strengthened human resources for health, improved supply chain management systems, and support to results based financing.*

GHI directly aligns with DRC's National Health Development Plan (PNDS) with the goal of moving toward sustainable health systems and health care services, by making the health zone (HZ) network the key implementation unit, and increasing HZ program efficiencies, effectiveness, and mutual accountability. For the USG, this initiative includes smart integration between and among program elements and US agencies to the extent possible. As such, USG-supported programs in HIV/AIDS, malaria, tuberculosis, nutrition, family planning (FP) and reproductive health (RH), and maternal, newborn, and child health (MNCH) will be carefully aligned and leveraged across service delivery platforms. For example, HIV/AIDS programs that are primarily in major urban cities will scale-up prevention of mother to child transmission (PMTCT) interventions in high volume/high prevalence HZs through the rural integrated health program. HIV/AIDS programs will leverage malaria and FP/RH interventions into existing urban sites. USG-supported programs will continue to create linkages with other sector initiatives and projects such as sexual and gender-based violence (SGBV) and nutrition interventions through Food for Peace. Through strategic coordination, GHI is an opportunity to maximize program impact. By capitalizing on synergies within USG-supported programming, GHI builds on the considerable resources and achievements that the USG brings to

¹The central level includes the office of the Minister of Health, the Secretary General, and Directorates and national disease-specific programs; an intermediate level composed of 11 provincial health departments and 48 administrative health districts; and the peripheral level with 515 HZs with over 6,000 health centers.

DRC. These programs include *the President's Emergency Plan for AIDS Relief (PEPFAR)*, *the President's Malaria Initiative (PMI)*, and *Food for Peace new Multi-Year Assistance Program (MYAP)* activities. This effort also means better collaboration and synergy with key development partners in order to complement each other and to avoid duplication.

While gender issues are not highlighted in the PNDS, gender is a GHI priority in DRC. The DRC context is particularly challenging. Women in DRC suffer poor health outcomes disproportionately, and for the most part, are voiceless in the development of policies and services that affect them. Cultural norms that result in higher rates of girls' illiteracy constitute important barriers to women's participation in all levels of society. Women have less of a voice in government and parliament (e.g. Parliament 8.4%, Senate 4.6%) far from the 50% prescribed by the Constitution.² Moreover, the prevalence of SGBV is alarmingly high in conflict affected eastern DRC; and nationally nearly 75 percent of women reported some form of sexual, mental or other physical abuse.³

GHI provides the USG an opportunity to be effective in its approach to women, girls, and gender equality (WGGE). Under GHI, the USG, in close collaboration with the GDRC and other development partners, will leverage collaborative efforts through established strong partnerships. GHI provides an opportunity for the USG to ensure health investments are impacting the lives of women and children, the most vulnerable group in a society. Under GHI, the USG, in close collaboration with the GDRC and other development partners, will complete a gender analysis that will include all USG agencies and activities in DRC. As part of this analysis, particular attention will be focused on how social, economic and political barriers impact the lives and health status of women and girls in order to design comprehensive and effective programs. Behavior and social change interventions will target community leaders, men, women and policy makers, and service delivery efforts will target and promote positive male involvement.

Achieving results under GHI is predicated upon a number of assumptions. These assumptions include: 1) the GDRC remains committed to the health zone structure and that the minimum package of PHC interventions is provided along with other health reforms; 2) GHI supports national plans and priorities, is responsive to the national planning processes, and seeks to uphold national leadership and continued ownership by the GDRC; 3) the USG, Global Fund to Fight AIDS, Tuberculosis, and Malaria and other donor resources continue at projected levels; and 4) the political environment remains stable. Other issues might significantly impact the achievement of GHI and DRC health goals. These issues include the DRC's need to contribute to overall budgetary allocation to health as required to access Global Fund monies. Another potential issue is the upcoming elections scheduled for November 2011.

II. GHI Partner Country Priorities and Context

Context

The DRC has one of the lowest Gross National Incomes per capita in the world (\$160), with an estimated 80 percent of the total population of 67.8⁴ million living below the poverty line. Since

²Strategy of Growth and the Reduction of Poverty, DSCR 2, May 2011

³DRC Demographic and Health Survey, 2007

⁴Population Reference Bureau, World Population Data Sheet, 2011. http://www.prb.org/pdf11/2011population-data-sheet_eng.pdf

early 1991, the country has suffered a long decline from relative prosperity to disintegration during the decade of conflict that accompanied the collapse of the former Zaire. In 2010, the DRC was ranked 168 out of 169 countries in the Human Development Index, indicating it as the *second least* developed nation in the world. The country has vast natural resources (e.g., copper, cobalt, diamonds, and gold) and an annual GDP growth rate (2010) of 6.1%; yet this growth has not translated into an improved quality of life for most Congolese.

The 2007 Demographic and Health Survey (DHS) estimated life expectancy to be 43 years—the lowest of any country without a high HIV/AIDS prevalence. The status of key health indicators are among the worst in the world.

Table One: Health Indicators

Indicator	2007 DHS	2010 MICS
Family Planning		
Total Fertility Rate	6.3 children/woman	---
Modern Contraceptive Prevalence	5.8%	---
Unmet Need for Family Planning	24%	24%
Maternal Health		
Maternal Mortality	549/100,000 live births	---
Delivery in Facility (Public or Private)	70%	75%
Antenatal Care: 1 / >2 / 4 visits	84% / 79% / 47%	87% / --- / 44%
Skilled Attendant at Birth	74%	74%
Caesarean Section Rate	4%	---
Neonatal, Infant & Child Health (including malaria)		
Under-Five Mortality	148/1,000 live births	158/1,000 live births
Infant Mortality	92/1,000 live births	97/1,000 live births
Neonatal Mortality	42/1,000 live births	---
DPT3	45%	61%
Children with ARI Symptoms - Treatment	42% (seeking care)	42% (given antibiotic)
Children with Diarrhea Receiving ORT	62%	39%
Children with Fever Receiving Antimalarial Treatment	30%	39%
ITN Use: Children Under Five Years/Pregnant Women	11% / 12%	38% / 43%
HIV/AIDS		
HIV/AIDS Prevalence	1.3%	n/a
Number of Men and Women that Know Their HIV Status	9%	n/a
Highly Educated Women with Greater Incomes	3.2%	n/a
Use of Condoms with Casual Partners (women aged 15 to 24 years)	8.6%	6.0%

Nutrition		
Chronic Malnutrition (height/age of children under five years)	46%	43%
Acute Malnutrition (weight/height of children under five years)	10%	9%
Exclusive Breastfeeding 0-5 months	36%	37%
Anemia (children age 6-59 months)	71%	---
Vitamin A Supplement received in Past 6 Months (children age 6-59 months)	55%	---
Anemia (women of reproductive age)	60%	---
WASH		
Household Members Using Improved Water Source	48%	47%
Household Members Using Improved Sanitation Facility	18%	14%

Support of Host Government’s Vision for Improved Health: The GHI strategy is directly aligned with the DRC Ministry of Health’s *PNDS 2011-2015*, as well as with the *National Health System Strengthening Strategy*—the two key documents that prioritize the host government’s vision for improved health. The vision for the National Health Development Plan (PNDS) was shaped by an exercise that consolidated HZ level plans at the provincial and national levels and includes targets and a budget that is expected to come largely from external resources. The PNDS is a comprehensive plan that covers major causes of mortality and morbidity in the country. Among the key targets that the PNDS aims to achieve by 2015 are:

- 1) The reduction of maternal mortality from 549/100,000 to 322/100,000;
- 2) Reduction of under-five mortality from 92/1000 to 40/1000 live births;
- 3) Mitigate the spread of HIV/AIDS and reverse the current trends in malaria; and
- 4) Reduce by 2/3 the mortality and morbidity related to non-communicable diseases.

The GDRC aims to achieve these goals by improving the primary health care system through human resource development, strengthening the national pharmaceutical system, reforming the health care finance system, strengthening leadership and governance of the health system, and improving collaboration within the health sector and other sectors. All of the PNDS health area priorities closely align with the GHI strategy’s priorities, with the exception of GDRC’s priority #8—Emergencies and Catastrophes—which is not within GHI’s scope. Similarly, the FP/RH program component under GHI is not explicitly addressed in the PNDS. However, the GDRC emphasizes that FP/RH services are included as components of maternal health services.

DRC Health System: The health system in the DRC has three levels: a central level which includes the office of the Minister of Health, the Secretary General of the MOH, and Directorates of national disease-specific programs (HIV/AIDS; TB; malaria, etc.); an intermediate level composed of 11 provincial health departments and 48 administrative health districts; and the peripheral level with 515 HZs with over 6,000 health centers (HC). Over half of all HZs are supported by faith-based

organizations (FBOs) or non-governmental organizations (NGOs) structures. The health system also uses two types of unpaid community-based workers called community “*relais*.” Community health promoters (*promotion relais*) are limited to health promotion and community mobilization activities, while community treatment workers (*treatment relais*) deliver a limited set of interventions (i.e. treatment of diarrhea, fever, and referral of malnourished children to health facilities, plus distribution of a limited range of FP commodities). Community treatment workers are selected based on a higher level of education and having an established source of remuneration, independent of their health work.

Each of the 515 health zones has a General Referral Hospital (GRH). FBOs own 34 percent of these hospitals, which are integrated into the public health system. In most HZs supported by FBOs and NGOs, the MOH pays government workers’ salaries, which are extremely low (\$25 per month) and provides an additional salary supplemental incentives, known as *primes*. FBOs and NGOs often provide additional primes to health workers as well as providing essential drugs, lab equipment, commodities, and in-service training. As of 2009, the MOH estimates that 256 health zones—roughly half—are supported through service delivery contracts with FBOs or NGOs.⁵

The DRC also has a tiered essential medicines supply system under the National Essential Medicine Supply Program. There is a centralized pharmaceutical procurement system through the *nonprofit association* - Federation of Essential Medicine Procurement Agencies (FEDECAME), combined with a decentralized warehousing and distribution system supported by existing distribution hubs (CDRs). The USG, EU, and Belgium Corporation are providing significant technical assistance in supply chain management at various levels of the system to build capacity.

Partnerships: In a country as complex as DRC, partnerships are essential to accomplishing meaningful improvements in health and development. The health sector relies heavily on multilateral, bilateral, and financial organizations such as the Global Fund for assistance. The USG supports multilaterals such as the World Health Organization (WHO) and the United Nations Children’s Fund (UNICEF) particularly in polio eradication efforts, routine immunizations, and water and sanitation interventions. The USG also works closely with the private sector and has several public-private partnerships (PPP) dealing with safe blood supply and partnering with mining corporations to provide HIV/AIDS interventions.

Donor Coordination: The Health Donor Coordination Group (GIBS) and the National Executive Committee are the official coordination mechanisms in DRC used by donors and the government to coordinate health investments in the country, including those of civil societies. The USG is an active member and has worked steadily to increase coordination. The GIBS meetings are currently led by the EU and coordination meetings are held on a monthly basis. GIBS also has working groups or task forces that work on different themes such as human resource strengthening, supply chain management, and Results Based Financing (RBF). In 2012, the USG will take the lead in coordinating the Health donor group’s activities marking a unique opportunity under GHI to shape and influence governance and health systems strengthening (HSS).

⁵The USG does not anticipate paying *primes* under GHI.

The USG has worked steadily to increase strategic coordination and integration with a range of stakeholders. One example of improved coordination, under PEPFAR, is visible in the Partnership Framework and the draft Partnership Framework Implementation Plan.⁶ The USG is a member of the Global Funds' Country Coordinating Mechanism (CCM) and as Second Vice President in 2011 has actively pushed for CCM reforms, provided technical assistance to institute these reforms, and provided support to build the organizational, financial, management and technical capacity of the GDRC which resulted in the MOH being named as Principal Recipient in Round 9. The new PMTCT acceleration plan is another example of intra-USG strategic coordination with identified agencies providing assistance for selected inputs for all USG agencies (i.e. USAID using its mechanism to procure all PMTCT drugs for the USG, while CDC will provide PMTCT training to all USG partners). The USG participated in the development of the Country Assistance Framework (CAF), which defines the basic consensus among 19 major bilateral and multilateral donors on coordinated approaches to programming and common results. The CAF provides the context for USG development support to the GDRC and is derived from DRC's Poverty Reduction Strategy Paper (PRSP).

Challenges: Fundamental problems hinder the GDRC's ability to provide quality health services. The proportion of the budget devoted to health is estimated at 2.9 percent of actual health expenditures in 2010,⁷ a decline from 5.4 percent in 2009. According to the National Health Account (NHA), the out of pocket spending for health is 43 percent.

There is a lack of reliable, up to date information on HR; staffing needs are not quantified; there is inequitable distribution of health workers and the quality of nursing and medical training is declining. Government salaries are low and salary payments are infrequent and unreliable, with health workers reporting months of not receiving their salaries. In some areas, the country's transition from humanitarian (free) assistance to a fee-for-service system has been a management and financial challenge, especially given the high level of poverty.

Drug management systems are weak and lack accountability, with multiple parallel systems in place and frequent stock-outs. Drug prices are also not fixed and vary across facilities. Many donors, including the USG, operate parallel procurement systems, since the FEDECAME procurement system currently does not procure condoms, anti-retrovirals, or contraceptives. Nevertheless, once procured, most donors store their drugs and health commodities at the CDRs, from there they are distributed to the zonal level and health facilities.

Existing health facilities have high operating costs, logistical constraints, and weak supervision and oversight. Tenuous infrastructure, such as inadequate roads and the lack of electricity and water at many health facilities, complicates access. Political instability and a rapid rate of population growth further limit the GDRC's ability to provide basic services.

Opportunities: Despite the challenges cited above there are important initiatives and efforts upon which the GHI strategy will build on. For example, the GDRC with support from the World Bank and the EU provide essential drugs, capacity building, and equipment and rehabilitate medical training institutions and health centers. The USG will continue to work in tandem with other key partners

⁶Partnership frameworks are five-year joint strategic agreements for cooperation between the U.S. government and partner governments to combat HIV/AIDS in the partner country through technical assistance, support for service delivery, policy reform, and coordinated funding commitments.

⁷Ministry of Finance. DRC, Preliminary 2010 Budget. Actual expenditures are typically lower than budgeted.

such as the Japan International Cooperation Agency (JICA) on strengthening human resources for health.

The Essential Medicines List was revised and updated with USG assistance to include critical maternal, newborn, and child health (MNCH) and FP commodities, and adopted by the GDRC in March 2010. A policy tool on FP/HIV integration was designed to integrate FP interventions into voluntary counseling and testing (VCT). In November 2010, the DRC was named a U.S. President's Malaria Initiative (PMI) country, which will bring additional resources for malaria interventions. Additionally, the MOH, along with multiple stakeholders developed and approved a new and improved maternal and newborn health policy. A Newborn Health Task Force was established under the leadership of the National Reproductive Health Program, with the participation of donors (WHO, UNICEF, USAID, and UNFPA) and implementing partners.

With respect to RBF, several donors, such as the EU, CORDAID, GTZ and the World Bank are supporting pilot studies and evaluations of different models of the program. Though research is ongoing, a base of knowledge and data is being developed that creates a foundation for successful scale up of RBF, as seen in neighboring countries of Rwanda and Burundi. The current RBF landscape in the DRC is quite complex. The past and current projects supported by the other donors have followed particular paths in their development in order to adapt to the context in which it operated. These varied approaches have led to different features and arrangements. By learning from these early experiences and by using them as a basis, GHI will pilot RBF in appropriate USG health sites.

The GDRC has established a national gender coordination working group with the support of the United Nations (UN) agencies. Internally, the USG has a sexual and gender-based violence (SGBV) working group and is in the process of putting in place an inter-agency gender working group. These working groups will provide a platform to elevate gender issues facing DRC and have a strategic and coordinated approach to support the country. Through this GHI gender work, USG will also contribute to USG's 2010 *Strategy to Address Sexual and Gender-Based Violence* (that includes an objective on "increased access to quality services for survivors of SGBV"), and will contribute to the UN/GDRC Comprehensive Strategy in the Fight Against Sexual Violence and the National GBV strategy. The gender assessment that the USG has scheduled to conduct in January – February 2012⁸ will provide an excellent opportunity to understand the social, economic, and political issues that impede women's progress, and the most effective and appropriate interventions for DRC.

One of the major highlights under GHI has been the active engagement and participation of the GDRC in the formalization and integration of three cross-cutting areas within the MOH. The June 2011 strategic planning workshop, chaired by the Minister of Health was used to orient the GDRC and the USG to the underlying principles of GHI and to reflect on a multiyear road map that could save resources, increase efficiencies, and accelerate progress towards better health outcomes. Some of the major outcomes of the strategic workshop were: to confirm that the USG was supporting GDRC health priorities, to discuss how smart integration could increase efficiencies, and to select and agree upon three cross-cutting issues for which an intensified focus might rapidly accelerate progress towards achieving the MDGs country goals. As a direct outcome of the high level workshop, it was

⁸ The Gender Assessment was postponed from October/November 2011 as it was determined that sending teams of interviewers into the field right before the November Presidential elections could put their personal safety at risk.

suggested to institutionalize the three cross-cutting issues (HRH, SCM, and RBF) and make those technical Task Forces not separate, but part of the government's standing committees on the same issues to achieve greater synergy. These working groups will be used as a way for the USG to work directly with the MOH and various other stakeholders to maximize resources, increase collaboration and ensure that activities will actively strive towards sustainability.

III. Current USG Programs

There are four USG agencies that work in the health sector in the DRC. Each agency focuses on its comparative advantages to incorporate a whole of government approach to health. The U.S. Agency for International Development (USAID) is providing a comprehensive package of PHC services in 80 HZ in South Kivu, Katanga, East and Western Kasai provinces. USAID's MNCH and FP/RH program focuses on increasing availability of and access to low-cost, high-impact interventions. USAID also provides HIV prevention, and care interventions in high prevalent urban sites for OVCs and PLWAs. Both the Centers for Disease Control and Prevention (CDC) and USAID are supporting considerable funding to tuberculosis (TB). For example, CDC is strengthening the laboratory diagnosis of TB and USAID supports DOTS expansion, increasing TB case notifications and TB diagnosis and quality treatment as part of the PHC package. Although CDC has limited sites for monkey pox (one site) and avian influenza (four sites) surveillance, and provides emergency technical assistance for polio containment, the main focus of CDC's work is in HIV/AIDS. CDC is strengthening HIV-specific laboratory capability, HIV/AIDS information systems and surveillance, and HIV/AIDS care and treatment. The USG currently supports activities that contribute to the reduction of HIV prevalence while increasing access to quality HIV/AIDS prevention, care, and support in high prevalence urban sites. The Department of Defense (DOD) is also working to provide HIV preventive services including HIV testing and counseling (HTC) to the military and their families while providing care to the surrounding communities in four sites in Kinshasa, Katanga, East Kasai, and South Kivu. Currently, USG agencies have ongoing HRH and SCM strengthening activities; however, there are no USG agencies that are implementing Results Based Financing (RBF) activities—this will be an entirely new area of focus.

Ongoing Human Resources for Health Activities: The USG is providing technical assistance to the GDRC health sector at the national, provincial, zonal, and community levels to strengthen capacity in planning, coordination, supervision, monitoring, and evaluation. Examples of these activities include:

- Providing central level technical support to assist the National Malaria Control program in the development and submission of the successful Global Fund Round 10 proposal;
- Sponsor the WHO/National Program Officer (NPO) for Malaria - an advisor to the National Malaria Control Program and the WHO/NPO/TB Advisor to the National TB Control Program.
- Providing laboratory strengthening activities, including procurement of equipment and training of laboratory technicians;
- Providing trainings to increase the leadership and governance capacity building for provincial staff in 24 HZs;

- Providing blood safety and security assistance to the National Transfusion Center and the reference hospitals in the HZs;
- Strengthening the skill set of the community health workers to improve their ability to deliver effective health messages around several key topics, including: nutrition, HIV, FP and malaria at the community level;
- Working with the Kinshasa School of Public Health to improve management, re-organize the financial office, and provide scholarships for Doctoral and MPH students.

Ongoing Supply Chain Management Activities: Current USG activities are working to improve drug management, logistics and distribution, throughout the DRC. Examples of these activities include:

- Providing technical assistance for supply chain management and logistics to CDAs (Regional Distribution Centers) to strengthen pharmaceutical management related to forecasting, procurement, inventory management, and drug management systems;
- Increasing the supply chain effectiveness at the provincial and health zone levels -- the information generated will permit early stock-out alert, prompting appropriate corrective measures;
- Assisting the National Reproductive Health Program to build its capacity for improved coordination in the area of commodity security.

Ongoing GDRC Results Based Financing Activities: The USG has conducted an assessment of RBF activities in DRC in preparation of the Global Funds' Round 9 grant, which is focused on health systems strengthening and will undertake RBF activities. Under GHI the integrated health project will pilot RBF in selected HZs. Please refer to section IV for a description of planned activities.

IV. GHI

A. Objectives, Program Structure, and Implementation

The USG's Priority Goal in the FY 2009 to FY 2013 **Country Assistance Strategy** is to "Improve the Health Condition of the Congolese People." To reach this goal, the USG will build upon three key pillars: 1) Strengthened Health Systems; 2) Improved Access to Quality Integrated Health Services; and 3) Increased Demand for Quality Integrated Health Services. Focused activities within each of these pillars will lead to increased utilization of quality health services by the Congolese population and ultimately contribute to the reduction of maternal, newborn, and child mortality and morbidity, as well as, reduce the burden of infectious diseases, specifically malaria, tuberculosis, and HIV/AIDS. Under GHI, the GDRC and USG have decided to intensively focus on three cross-cutting issues to assure maximum impact and accelerate progress towards the MDGs: **1) Strengthened Human Resources for Health, 2) Improved Supply Chain Management Systems, and 3) Results Based Financing.** These areas were selected based on GDRC's priorities, USG comparative advantages, and opportunities for leveraging USG resources as well as those of other donors. Concerted efforts in these focus areas will further reinforce programmatic interventions in MNCH and communicable diseases and help move the DRC closer to achieving the overarching goal of "Improved Health of the Congolese People."

Moreover, the GHI principles serve as the basis for the USG's GHI strategy and the USG believes that coordinated application of GHI principles across these focus areas will result in significant and sustained health improvements. Please refer to page 16 for details on how the principles shape and inform the GHI DRC strategy. For the three cross-cutting areas, the following rationale and activities have been identified as follows:

Cross-Cutting Area #1: Strengthened Human Resources for Health

Rationale: Similar to many African countries, the DRC's HRH challenges are rooted in lack of professional development and mentoring opportunities to develop adequate capacity. However, in the case of DRC these "common" challenges are exacerbated by the country's vast size, extremely poor infrastructure, and public servant salaries that are very low if provided at all. According to the WHO HRH database, in 2004, the ratio of health workers per population was extremely low: 0.11 of physicians, 0.53 percent of nurses-midwives, and 0.02 percent of pharmaceutical staff per 1,000 of the population. The underlying hypothesis for strengthening human resources is that the health status of the Congolese people will not improve unless overall health education improves and health personnel are skilled, delivering both preventive and curative services, that are accessible (close and reasonably priced), and equitable (offered to the entire population).

With respect to HRH, the GDRC envisions four strategies to address the issue: 1) strengthening basic training at the secondary, higher and university levels; 2) increasing the efficient and rational use of human resources; 3) building on-the-job human resources capacities; and 4) improving social and working conditions for health workers. The USG has been supporting the GDRC to improve its human resource capacity through training of service providers at the central, provincial, zonal, and community levels as well as support to pre-service institutions. USG assistance has focused not only in technical areas such as MCH/FP/HIV/nutrition/malaria, but also as targeted management and governance areas. Furthermore, while the GHI cross-cutting area # 1 is focused on HRH, the USG believes that working *in tandem on the other GHI cross-cutting areas #2 and #3* will mitigate some of the underlying challenges that contribute to an inherently weak HRH base.

Under GHI the USG, in close collaboration with the GDRC and key development partners, will continue to assist the Congolese government meet its challenges in HR. Ongoing HR activities will continue to be supported under GHI. By taking stock of each USG partner's contribution towards HRH, and leveraging with other donors where possible, the USG will provide strategic support to the GDRC to implement the following *new illustrative* activities:

- Assessing at the national level to determine what governance and management skills are needed by health personnel at different levels and the most efficient method to ensure they acquire these skills;
- Assessing the workforce to identify how to retain health personnel, developing incentives to re-distribute health personnel to geographic areas lacking staff, and increase selected health specialties' to retain them in the public sector;
- Scaling up governance and leadership training in an additional 56 HZs focused on provincial, district, and health zone technical teams;
- Assisting the GDRC to finalize national protocol for clinical care for sexual assault survivors and roll out training of service providers the provision of care;

- Under the Nurse Education Partnership Initiative (NEPI), increasing the numbers and quality of midwives graduating annually and improve the curriculum of midwives training schools;
- Scaling up and integrating PMTCT services in antenatal care (ANC) clinics in Kinshasa (currently in 54/560 sites); and in 175 sites in 120 HZs outside Kinshasa. PMTCT services will more than double in the first year of the PMTCT acceleration plan;
- Providing training in fistula prevention and treatment for health personnel supported by the Integrated Health Project (IHP);⁹
- Increasing SGBV training for HZ personnel and community workers (scale up in 30 HZs in FY12);
- PMI comprehensive malaria package provided and trainings in malaria case management will be initiated in 42 supplemental health zones in Kasai and Katanga provinces;
- Joint PEPFAR agencies implementation and operational plan for Kisangani with integrated HIV/AIDS care and treatment capacity building in urban health facilities and surrounding community areas;
- Expand training of HIV/AIDS and SGBV for the Congolese military; and
- Results based Financing (RBF) training at provincial, zonal, and health center level for selected areas that will pilot RBF (see focus area # 3 for more details).

There are those persons that believe that building the capacity of human resources is not building sustainability because training is donor and funding depended. While capacity building is the bulk of GHI efforts, once individuals are trained the majority remain in country to provide services, or provide cascade training to others thereby creating sustainability within the system. The USG supports scholarships for more than 30 MPH and PhD candidates in country per year.¹⁰

Through concerted efforts, the USG will contribute to the following key GDRC goals under GHI:

Key GDRC/USG HR Goals
<ol style="list-style-type: none"> 1. The health sector has competent, performing and sufficient human resource available; 2. 30% of the population will receive quality health care and services by 2015; 3. Equitable distribution of human resources; 4. The capacity of health care managers and providers are strengthened to manage and provide quality health services; 5. There is a human resources capacity building plan in place to ensure regular training of services providers; 6. Increased utilization of health services; 7. Increased access to quality integrated health services; 8. Improved work and social conditions for health workers.

HRH Highlights from MNCH/HIV programs

- Training of all health workers on integrated messages will raise the awareness around MNCH/HIV, as well as gender issues;

⁹The Integrated Health Project (IHP), started in 2010, is a five-year bilateral arrangement funded by USAID.

¹⁰A current principle advisor to the Health Minister is a graduate of this program, contributing to the health development of the DRC.

- Expanded training of health care providers at the facility and community level in integrated package of health services such as MNCH/HIV/AIDS/post-partum FP will directly benefit women and girls;
- Training and technical assistance at the national and provincial level in policy development and problem-solving approach will build national capacity and lay a foundation for sustainability; and
- Through smart integration of training (e.g. FP, immunization, post-partum FP, etc.) the USG will attain efficiency and be more effective in improving access and quality of services provided, as well reduce financial burden on households.

Cross-Cutting Area # 2: Improved Supply Chain Management Systems

Rationale: A health system infrastructure that has all the appropriate essential medicines in stock allows for the timely administration of life saving treatment, resulting in saved lives and improved health. Currently, continual drug stock outs in all the disease areas of HIV, malaria, TB, and primary health care are creating increased risk to patients. The DRC currently has 19 different donor procurement systems in addition to the FEDECAME system, making it extremely difficult for the GDRRC to track the quantity, type and destination of drugs in the country. The lack of a consistent supply of essential drugs and vaccines, delivered in a timely fashion, results in increased deaths.

Strengthening the supply chain management is a priority for the GDRRC. The GDRRC envisions to: 1) increase funding and rational use of funding for essential drugs; 2) improve coordination of procurement of essential drugs; 3) strengthen the capacity of the national supply chain system; and 4) promote local production of essential drugs. Currently the USG is supporting the GDRRC in the first three aforementioned areas to improve drug management, logistics and distribution throughout the DRC.

Under GHI, the USG places a renewed emphasis on *strengthening the national drug supply chain* through capacity building of FEDECAME. FEDECAME is a non-profit organization created in October 2003 as a public-private partnership. FEDECAME has a Board of Directors composed of representatives from the MOH, Ministry of Finance, and Ministry of Budget, and the Regional Distribution Centers. It currently receives technical assistance from the Belgian Technical Cooperation and the EU. The GDRRC has granted FEDECAME the mission to procure, store, and distribute medicines for the country. FEDECAME has two functions: 1) the procurement of essential drugs through an internal agency the ‘Office of Coordinated Purchases’ (BCAF) Kinshasa comprising approximately 15 staff; and 2) storage and distribution conducted by the CDRs which are located in the provinces. In practical terms the FEDECAME system conducts the procurement and the CDRs manage the storage and distribution.

The USG considers the use of and strengthening of FEDECAME as critical to long term sustainability and has the potential to lead to better drug availability, cost effectiveness, reduction of drug stock-outs, and ultimately to the improved health of the population. Under GHI, the USG will collaborate with other development partners to complement and not duplicate efforts. By leveraging resources, the USG will continue its ongoing activities in this area and carry out the following *new illustrative* activities in an effort to strengthen the national essential drug system so it is functional:

- Conduct a Financial Management Risk Assessment (FMRA) *Stage 1, Rapid Appraisal* of FEDECAME and develop a plan to strengthen the FEDECAME system;
- Pilot limited direct procurement of essential drugs through the FEDECAME system; and
- Evaluation of timeliness, quality, and cost effectiveness of using the FEDECAME system over the parallel USG system (for comparison).

USG efforts in the aforementioned areas will contribute to the following key GDRC/USG goals

Key GDRC/USG Supply Chain Management Goals
1. Improved ability of host country to forecast, inventory and track;
2. Improved national ability to leverage resources for supply chain
3. Improved national capacity in SCM;
4. Improved coordination of procurement;
5. Improved availability of essential drugs in all health zones
6. Reduce stock out/improve access to essential drugs; and
7. 80% of essential drugs are of quality.

Improved Supply Chain Management Systems Highlights from HIV/Malaria program

- Long-term in-country technical assistance will continue to assist the MOH in strengthening pharmaceutical management related to forecasting, procurement, inventory management, and drug management systems building national system.
- Resources across the other health programs (TB, malaria, FP, HIV) will continue to support TA to strengthen the national drug management logistics.
- MCH and HIV/AIDS funds will be used to directly procure essential drugs for PHC and PMTCT programs.
- PEPFAR partners are scaling up SGBV services, particularly in the northeast DRC along with the Social Protection office of USAID, by procuring additional post-exposure prophylaxis (PEP) kits and other SGBV related commodities.

Cross-Cutting Area # 3: Results Based Financing

Rationale: As cited throughout the strategy, DRC is not short of challenges related to a fragmented health system that ultimately contributes to poor MNCH health outcomes. The degree of “quality” care and health facility utilization is directly tied to incentives used to motivate health workers. Public, private and faith-based health providers rely heavily on user fees to cover their operating costs, including staff salaries. In government facilities, salaries are low for those staff who receive them. Moreover, many posted staff are not on the civil service payroll and receive their remuneration from patient fees.

RBF is an approach that rewards the delivery of one or more outputs or results, by one or more incentives (financial or otherwise) upon verification that the agreed-upon results have actually been delivered. In the DRC, there has been increasing interest in using RBF as an approach that would motivate health workers and contribute to improving the quality of health care services and utilization of services. The results of RBF evaluations carried out in other countries demonstrate that the approach can have a significant impact on the use and quality of MNCH services. The

history of RBF in DRC dates back to 2002 when the World Bank launched a project in South Kivu. According to a recent World Bank report, a study in South Kivu province found that health zones supported by an NGO implementing RBF activities showed significantly better improvements in service utilization than zones without PBF receiving similar or higher resource flows.¹¹

At the request of the GDRC, the USAID supported Health Systems 20/20 project recently performed an assessment of the various RBF schemes in the DRC. The Health Systems 20/20 assessment report concluded that if certain pre-requisites were in place related to adequate infrastructure, such as, human resources and adequate supply of drugs, then the approach has the potential to be successfully carried out.

USG efforts to focus on RBF will bolster the GDRC overall goals in health care financing and contribute to the following key GDRC/USG goals:

Key GDRC/USG RBF Goals
1. Increased government budget allocated to health and improving budget execution and allocation;
2. Decreased fragmentation of international aid for the health sector;
3. Improved accessibility and quality of healthcare services;
4. Improved understanding of financial flows in the private sector to improve the allocation of this funding; and
5. Improved financial planning at the provincial level.

Under GHI as part of the learning agenda, the USG proposes to carry out the following new illustrative RBF-related activities:

- Carry out an assessment to determine which RBF mechanism can lead to greater efficiency and quality of service delivery through an operations research;
- Provide technical assistance to determine the role of RBF in PEPFAR PMTCT acceleration plan;
- Organize key stakeholder workshops to ensure the USG will share lessons learned with the GDRC and other development partners in order to inform RBF policy and implementation;
- Carry out RBF operations research to determine which financing mechanism can lead to greater efficiency and quality of service delivery;
- Identify eight HZs in different geographic areas of the integrated health program to pilot RBF;
- Promote a standardized approach to RBF; 1) support development of a manual, 2) provide technical assistance to the RBF cell in the MOH to ensure standardized indicators, and 3) train health managers on RBF management tools;
- Provide TA to the MOH’s Directorate of Studies and Planning to finalize the Guide for Operationalizing RBF;

¹¹*Dealing with Difficult Design Decisions: The experience of an RBF pilot program in Haut-Katanga District of Democratic, Bredekamp, Caryn et al, March 2011. World Bank. Note: Study did not control for confounding factor related to resource level.*

- Consider gender and explore the possibilities of the inclusion of clinical standard for patients who seek care for sexual violence (i.e., rape) such as ensuring psycho-social support and post-exposure prophylaxis, if appropriate for the HZs selected; and
- Conduct an external evaluation for the IHP RBF activities along with continuing monitoring of the control and pilot areas.

RBF has increasing visibility in the national health policy dialogue, particularly in the context of decentralization whereby the provinces would become responsible for government health worker salaries. The USG, under GHI, is well positioned to support a pilot of RBF in USG sites, as well as to inform the process of standardizing an approach to RBF. If this practice proves to be successful and demonstrates increased results under key indicators, the USG will direct additional resources to expand RBF to a greater number of health zones.¹² In addition, depending on resources, the USG may support illustrative research activities for other health financing approaches, such as *mutuelles* (community based insurance) and fee-for-service, to determine the most efficient method of paying for health care.

B. Focus Areas and the Link to GHI Principles

Focus on Women, Girls, and Gender Equality: The GHI strategy will promote the principle of Women, Girls, and Gender equality throughout its program activities in DRC. USAID interventions focus on the rehabilitation and strengthening of the health system by enabling basic quality health care services, with a particular emphasis on women through increased access to and quality of MCH, FP, and RH services. Examples include: gender consideration in the design of behavior and social change activities; the identification of program beneficiaries including community health workers, program trainees and fellowship recipients; and identifying the barriers to their participation in the design, implementation and evaluation of the interventions provided. In addition, increased delivery of WASH activities to increase access to potable water will allow more women the opportunity to explore income-generating opportunities and girls to attend school. Program activities will also seek to involve men into FP, MNCH, and PMTCT activities. Please refer to entire strategy for references to gender considerations under GHI. Some other examples of potential activities that may arise as recommendations from the planned USG gender assessment include technical assistance to the GDRC to develop a national gender policy and strategy and education and communication programs particularly at the community level to reduce harmful gender norms, GBV, and gender inequities.

Encourage Country Ownership and Invest in Country-Led Plans: Recognizing the pressing social needs, the GDRC is implementing its own strategies and systems to achieve tangible progress in rebuilding basic health services. The GHI strategy is aligned with and supports the goals and targets set forth by the GDRC in the PNDS and other disease specific national plans. Furthermore, the three focus areas of the GHI strategy were identified by the GDRC as its own national priorities. The indicators that will be used to measure the impact of these interventions were agreed upon in collaboration with the GDRC to ensure that they could be measurable using existing government surveillance systems.

¹² Expansion will depend on the results of the external evaluation and on the availability of resources.

The activities outlined throughout the GHI strategy aim to make progress towards meeting the desired goals and targets declared by the GDRC. For example, the GDRC's *National Roadmap to Accelerate the Reduction of Maternal Mortality* calls for: 1) improving the capacity of healthcare providers and community members to detect early danger signs recognition, develop a quality national referral system, and improve the capacity of health facilities to provide prompt emergency obstetrical care; 2) increasing the quality of services provided to women during pregnancy, delivery and post-partum periods; 3) increasing coverage and quality of basic and emergency obstetrical care during pregnancy, delivery and post-partum; and 4) improving birth spacing through increasing access to and voluntary use of modern contraceptive methods. Current and future activities undertaken by the USG to improve human resources for health and strengthening supply chain management systems are designed to have a direct impact on these health outcomes desired by the GDRC.

Increase Impact Through Strategic Coordination and Integration: The USG is working to increase its impact through strategic coordination and integration by using the whole of government approach to expand HIV/AIDS services into Kisangani—first by bringing USG agencies together to complete an assessment of the area, and then by working with other donor partners to develop joint work plans that will result in a complete continuum of services. Prevention, care and treatment services in Kisangani will also focus on the military and will be coordinated with complementary PEPFAR activities supported by the DOD—for example, the use of military spouse associations to encourage the number of females seeking HIV/AIDS services. In addition, PEPFAR has commenced efforts to integrate activities into all USG program locations; this integration effort includes expanding PMTCT services into 80 rural health zones where USAID is providing PHC services and the implementation of a family-centered continuum of care, including providing ARVs, to TB-HIV co-infected patients in primary health care settings. Through the use of one of our TB strengthening mechanisms, HIV test kits will be provided to TB diagnostic and treatment centers and co-infected patients will be referred to access ARVs. In addition, USAID and CDC programs will support safe blood activities in these zones as well. Also, PEPFAR is scaling up SGBV services and referrals, particularly in the northeast of the country.

Other examples of smart integration that will be enhanced under GHI include: 1) integrating FP services into postpartum maternal care, as well as other contacts during the post-partum period, such as immunization services by counseling on healthy timing and spacing of pregnancies and providing FP services, including lactational amenorrhea methods (LAM) and intrauterine devices (IUD), during the hospital stay. In addition, long lasting insecticide treated nets (LLIN) will be distributed in coordination with the PHC program—as nets will be distributed at the health center once the child is fully vaccinated to encourage the increase of fully vaccinated children.¹³ Also, while intermittent preventive treatment of pregnant women (IPTp) is a malaria prevention intervention, oversight for the program is conducted by the National Reproductive Health Program, to ensure further integration.

¹³Distribution of LLIN to fully vaccinated children is a GDRC policy. The rationale is twofold: 1) children under 12 months generally sleep with their mothers, who received a LLIN during a prior antenatal visit; and 2) there is currently an ongoing universal bed net coverage campaign which provides one LLIN for every two individuals in the household. As a result, unvaccinated children should be covered from one of these interventions.

Strengthen and Leverage Other Efforts: The USG will assist the GDRC in increasing efforts to coordinate and leverage funds from other donors to achieve maximum health outcomes. An example of this can be seen in the malaria portfolio. Through PMI, malaria prevention and case management services will be extended beyond the 80 HZs covered by the integrated health program, to include an additional 66 HZs. PMI is leveraging the resources of: the Global Fund round 8 and 10 awards, the World Bank Booster program II, UNICEF, and the Korean International Cooperation. USAID is working with the Global Fund, and World Bank to ensure universal ITN coverage before the end of 2011.

As RBF is rolled out under Round 9 of the Global Fund, the USG will seek opportunities for joint trainings, and discuss possibilities of Global Fund resources for RBF in selected USG health zones. GAVI supports health system strengthening, rehabilitation of health centers and supplemental essential medicines in selected HZs that sometimes overlap with our integrated health program. Close coordination in conjunction with GDRC and GAVI is required to ensure no duplication occurs.

No one partner or donor has sufficient resources or health zones to have a significant impact on national level indicators. It is only by a concerted effort on the part of the GDRC, donors, and financial institutions that improvements in health will occur. The Global Fund is the major provider of commodities for TB, malaria and HIV/AIDS for the DRC. It will also, under Round 9, support RBF in HZs without an implementing partner. The USG will continue to provide technical assistance to build the capacity of the GDRC central RBF unit to implement RBF, and to fully implement its responsibilities as a Principal Recipient for the Global Fund Round 9. This assistance is increasingly important to ensure efficient and accountable use of funds.

Build Sustainability through Health Systems Strengthening: Throughout all of the disease interventions, the USG is seeking ways to assist the GDRC strengthen the health infrastructure from the national to the community level through: institutional and HR capacity building, lab and infrastructure, logistics and pharmaceutical support, strategic information and health finance. The USG is providing long-term in-country technical assistance to help strengthen pharmaceutical management related to forecasting, procurement, inventory management, and drug management system. Assistance is being provided to support a WHO Malaria Advisor to sit within the National Malaria Control Program (NMCP) to strengthen the capacity of the NMCP at the national level in strategic planning, policies, guidelines and M&E planning. Under GHI, we will continue to build and assist the GDRC in a range of policies such as: retaining HRH, forecasting of pharmaceutical needs at national and provincial levels, addressing the FP/RH needs of adolescents, assessing the community treatment relays' abilities to use malaria rapid tests and correctly treat children under five with ACTs, using the NHA data to advocate for increased health budget resources, establishing national standardized indicators and a manual for RBF interventions, and task shifting of ARV treatment to nursing staff.

As a key approach to ensuring improved health outcomes, the USG health programs will also focus on social and behavior change efforts. Management and leadership trainings at the various levels of the health system ensure that the HZ is managed effectively and that quality services are provided. Improving the quality of services is embedded in the delivery approaches, through policy development at the national and provincial level and problem-solving approaches or quality

assurance methods that engage the service providers and communities to tackle their own identified problems. While working at the community level with the community health workers and beneficiaries, gender concerns will be addressed. Also, issues around quality assurance will be addressed when the service providers and community volunteers are updated or trained in high impact interventions such as active management of the third stage of labor (AMTSL) and essential newborn care for providers and community volunteers.

In addition, under the crosscutting area #2—improved supply chain management systems—the use of FEDECAME to procure essential drugs will build sustainability of a local institution. If direct procurement using the FEDECAME system is successful, then the USG will provide additional funds each year, ordering through FEDECAME and will encourage other donors to do the same.

V. Monitoring, Evaluation, and Learning Agenda

The USG/DRC GHI results framework seeks to contribute to the MDG goals, 4, 5 and 6: reduction in maternal, neonatal and child morbidity and mortality and reduction in the incidence of communicable diseases. To achieve these goals, USG assistance under GHI will focus in three pillar result areas: Intermediate Result # 1. Strengthened Human Resources for Health; Intermediate Result # 2. Improved Supply Chain Management Systems; and, Intermediate Result # 3. Support to Results Based Financing.

The USG will use impact, output and process level indicators to measure the progress of its efforts under GHI. Indicators will be a combination of GDRC indicators and standard USG Foreign Assistance indicators. The Demographic and Health Survey will serve as the primary data source for the USG to assess progress on impact-level indicators such as maternal, neonatal and child mortality, modern contraceptive prevalence rate, total fertility rate, HIV, and malaria prevalence. The first DHS was conducted in 2007 and one is planned for 2012. Other primary data sources such as the malaria indicator survey and specific surveillance data systems (i.e. ANC sentinel-surveillance) will be utilized to track progress for selected indicators in HIV and malaria on a bi-annual basis.

A countrywide gender assessment is scheduled for January/February 2012 with input from the USG agencies in collaboration with the GDRC, other development partners, and civil society. As part of this analysis, particular attention will be focused on how social, economic, and political barriers impact the lives and health status of women, girls, and gender equality in DRC. The analysis report is set to be finalized in March 2012 and the information obtained through this analysis will be used to inform new program design and implement future activities under GHI.

The GDRC health management information system is identified as weak. The need for reliable data for decision making is strongly endorsed by health stakeholders. By jointly planning the various resources from the USG, along with other resources, the USG provides limited support to the GDRC in this area. Currently the USG provides assistance to the GDRC in: 1) developing standard national indicators; 2) training national cadre in HIV/AIDS HMIS and M&E at the national level; and 3) capacity building of health care providers at the provincial and zonal level in supervision, monitoring, data quality and the use of data for decision making through training. The USG relies primarily on routine program reports from its implementing partners for information on progress on

output and process level indicators in USG target zones and less on the national system which is unable to provide timely reports. Key Impact indicators the USG will track include:

- Reduction of maternal and child mortality;
- Reduction in malaria burden in at risk population;
- Increased immunization coverage;
- Reduction in malnutrition;
- Increase in modern contraceptive prevalence rate; and
- Reduction in HIV/AIDS prevalence in the general population;

The GHI focus areas will be assessed using cross-cutting GHI indicators currently under development. As part of the Monitoring and Evaluation strategy, information will be disaggregated by sex and age to measure the impact of GHI activities on the improved health status of the Congolese population. Particular attention will also be focused on maternal and child mortality and morbidity rates in areas where specific GHI activities are implemented. In addition, to assess the quality of impact of the activities undertaken in the HRH cross-cutting area, attention will be paid to determine if there is an increase in HRH indicators that focus solely on women and girls—percentage of births attended by a skilled birth attendant, modern contraceptive prevalence rate, and proportion of women who have completed a pregnancy who have received two or more doses of IPTp.

Research and Evaluation: In addition to the DHS and other surveys mentioned above, the USG will continue to conduct routine project and program external evaluation to assess the impact of its investment under GHI as well as answer key evaluation questions that it will identify. The USG recognizes the importance of operational research. Although resources are limited, the USG, in close collaboration with the GDRC and other partners, will identify opportunities to conduct operational research, which, will help improve the overall quality of services in DRC.

Reporting. The USG will report performance metrics to headquarters on an annual basis, using the Performance Plan and Report submitted each December through the Foreign Assistance Coordination and Tracking System (FACTS). In addition, the USG will report on HIV/AIDS Next Generation Indicators bi-annually through the semi-annual report and the annual report.

Coordination The USG will continue to coordinate with existing national and partner's M&E coordination mechanisms on a bi-annual basis to promote learning and ensure harmony among the USG, GDRC, GF and other development partners. The GDRC conducts an annual review of the activities performed by its development partners.

Learning Agenda: The GHI strategy outlines a learning agenda that will explore the impact of cross-cutting issues on the improvement of quality health services received by the Congolese people. *Two of the cross-cutting focus areas* will be studied intently to identify the lessons learned and to share those lessons with the GDRC and other stakeholders.

Cross Cutting Focus Area #2: Strengthening the supply chain system in the DRC through the use of the host country procurement system, has the potential to lead to better drug availability, cost

effectiveness, and reduction of drug stock outs. USAID will request technical partners with drug logistics expertise to monitor and evaluate how FEDECAME manages direct procurement requests from USAID. The following indicators were developed by the GDRC and USG to measure the feasibility of using FEDECAME:

1. Capacity to complete an order in 6 to 8 months [from the time the order is confirmed to the time the goods are delivered in the warehouse (management)];
2. Number of substandard/ non-compliant products found in the consignment coming from prequalified sources (Target 0) (Quality control);
3. Availability of all sentinel medicines at all times (Target: >95%) (availability of products).

These indicators will be compared with the IHP rural project, which is currently procuring essential drugs and brings them into the country. If the FEDECAME system does a satisfactory/or better job of procuring drugs, then a greater volume and amount of drugs will be ordered via FEDECAME.

Cross Cutting Focus Area #3: The Integrated Health Project will be the staging ground to examine whether another cross-cutting focus area, RBF, leads to greater efficiency and quality of service delivery. The USG will select eight supported health zones, using all the health facilities in that zone, to pilot PBF and compare the performance of these health zones in key indicators with control health zones not using PBF. The methodology will clearly spell out the criteria for selection and identify in advance what indicators will be examined. A control set of HZs will also be selected that will receive the same inputs (i.e. training, equipment, supervision) but without a bonus for performance for the health facility. Under RBF, if the health center achieves their target, they will receive incentives. The health center will determine how to distribute their incentives: renovating the HC, buying additional drugs, and topping up salaries of staff that performed well, are some of the options. A rigorous external monitoring and evaluation will be undertaken to determine what factors were motivating for personnel. Quantitative targets can lead to an over-exaggeration of results, there will be an effort to have qualitative targets to encourage that work completed is of a standard level of quality. The custom GHI indicators developed were:¹⁴

- Number/percent of children < than 12 months of age, who received DPT3 in PBF supported HZs compared to non-PBF HZs;
- Number of ITNs distributed to priority populations (pregnant women and children under five) in RBF supported HZs compared to non-RBF HZs; and
- Completion rate of performance evaluations (i.e. evaluations done by pre-determined local NGOs or provincial/zonal technical teams to confirm results) by level and by facility.

Health zones supported by the USG do not provide “primes” to staff. The unreliability of government salaries is a major source of demotivation.

¹⁴The custom indicators were designed to monitor progress of the three cross-cutting areas.

VI. GHI Communication and Management Plan

The GHI in DRC will establish a robust whole-of-government, multi-layer communication strategy, reflecting the underlying principles of the President's initiative. This communication strategy will benefit the full complement of the USG health portfolio in DRC. As with the management strategy, GHI in DRC will build upon the new GHI interagency management platform. There are three components of the strategy, all aiming to enhance dialogue, learning, and recognition of the USG's partnership in the DRC:

1. Internal USG Communications

- Strengthen internal communications within GHI to ensure a commitment to inclusiveness, transparency and to enhance participation at all levels.
- Engage proactively with the U.S. Embassy's Public Diplomacy staff and USAID's Communication Officer to develop a clear Mission-wide communication and outreach strategy (maximizing use of innovative media).

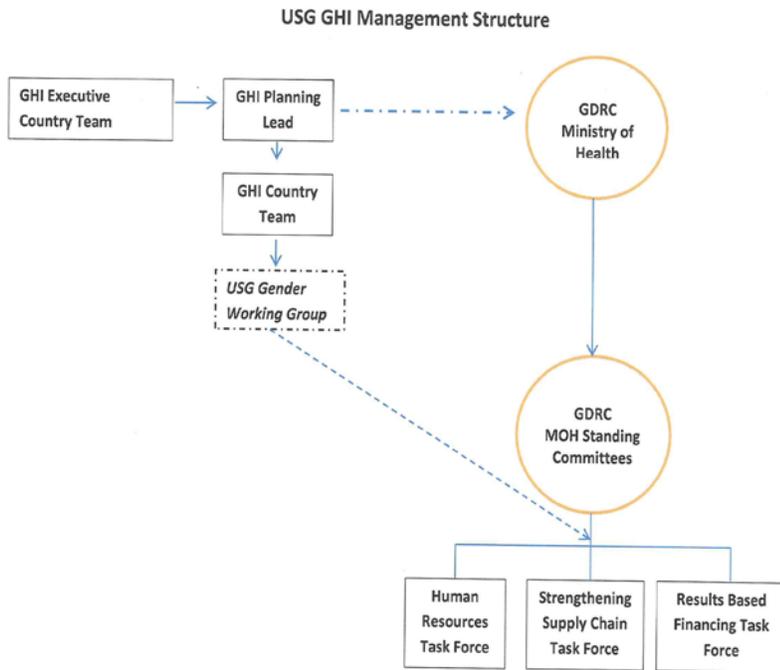
2. Support Interagency HQ-Field communications

- Produce informative communications planning between GHI in DRC and GHI HQ by ensuring regular updates between the convening and planning leads.
- Formulate protocols to manage any and all-anticipated visitors to maximize benefit of in-country missions and minimize impact on technical staff.

3. Bilateral USG-GDRC Communications

- Create a calendar of key events and work with GDRC counterparts to plan and prepare for key engagements (at all levels of government) to ensure inclusive dialogue, and reduce any additive burden to all parties by mainstreaming GHI into existing schedules.
- Provide support to and strengthen the capacity of the GDRC to develop and execute targeted communication strategies that enhance and promote the DRC government's initiatives to improve health service and health outcomes.
- Develop a whole-of-government media management strategy that ensures that agency-specific technical contributions and support to the GDRC are recognized.
- Collaborate with USG DRC partners, health sector stakeholders, and other donors to identify joint opportunities.
- Engage local and international media to enhance coverage and reporting of GHI initiatives. and
- Document achievements and successes of GHI to share with GHI-HQ staff and in turn share with key partners.

Management Plan: With a whole of USG approach central to GHI, the need to leverage and coordinate better with the Global Fund and other major donors, and the overriding desire to place country ownership and coordination center stage, there is an opportunity to design a new management structure. USAID was named the GHI Planning Lead. Building on the existing PEPFAR



structure, the GHI Executive Country Team is composed of the Deputy Chief of Mission, the USAID Director, the CDC Country Director, the PEPFAR Coordinator, the DOD country representative, and the USAID Planning Lead. The GHI Executive Country Team will have periodic briefings from the Health Donor Group (GIBS) Chair and USG members of the Global Fund CCM.

Bi-annual meetings are proposed that would bring the GDRC and USG team together to complete joint portfolio reviews. In addition, an annual meeting of USG implementing partners and other stakeholders will be convened

under the direction of the MOH to evaluate progress towards achieving GHI indicators. In January 2012, USAID will also take the position of Coordinator of the GIBS (Health Donor Coordinating Group) and it has a unique opportunity to influence the direction and focus of the various donor partners in DRC. In preparing the GHI strategy and creating the data call slides, the results framework, and the various disease matrices, it was clear that the USG resources alone are not sufficient to address all of the needs of the DRC. The only way to achieve real impact will be in forming a coordinated and united partnership between the government, donors, civil society, and other stakeholders.

VII. Linking High Level Goals to Programs

USAID’s Operational Plans (OP), PEPFAR’s Country Operational Plan (COP), and the PMI’s Malaria Operational Plan (MOP) were all instituted to support foreign assistance reform objectives, including improving the strategic alignment of our foreign assistance programs with policy priorities, increasing interagency coordination, and strengthening transparency and accountability in the use of funds. The eight GHI goal areas (i.e. HIV/AIDS, Malaria, TB, MNCH, etc.) are included in the OP and results are disaggregated by gender. The COP proposes new fiscal year HIV/AIDS programs and targets, while PMI focuses on malaria. All of these plans encompass the GHI principles particularly the WGGE, country ownership, health systems strengthening, the need for strong partnerships, and strategic coordination and integration. Each initiative has its specific indicators that are reported annually to Congress. At the country level all these initiatives work in concert to build GHI.

GHI places a specific emphasis on strengthening health systems. Recent guidance from Democracy/Governance (D/G)¹⁵ and the health sector explores how DG programs can be adapted to the health context to work with partner governments to: reform and build policy, enhance data gathering and analysis capabilities, increase public participation in health policy formulation and implementation, develop results based health management capacity, strengthen financial and program accountability, reform existing (health) systems, and support improvements to public health laws.

It is expected that the above initiatives will each contribute to the reduction of maternal and child morbidity and mortality. What is certain is that with every health component, the USG will ensure alignment across agencies through strong interagency collaboration and seek to harmonize contracting mechanisms to optimize greater efficiencies in the future. The end result will be the improved health of the Congolese people.

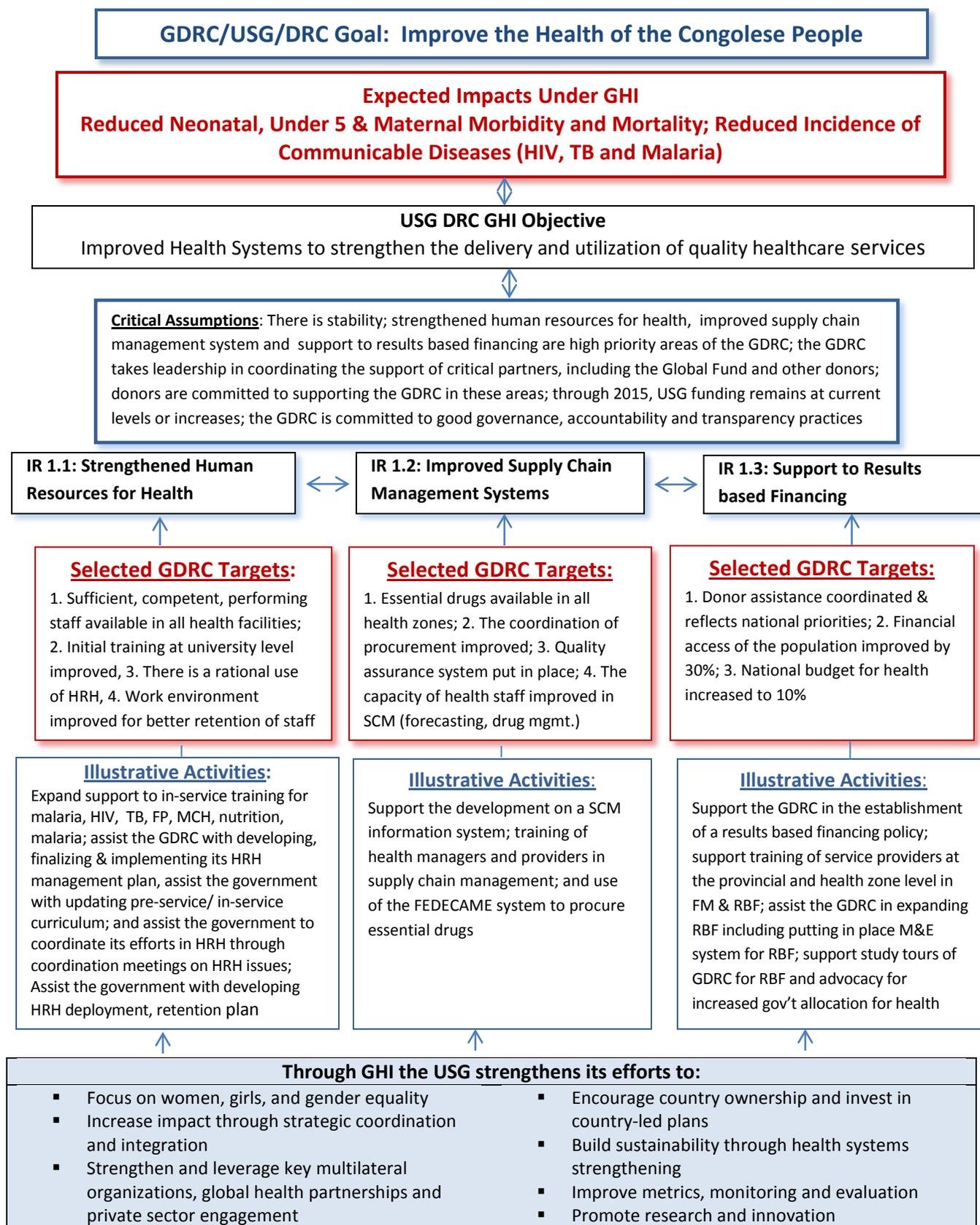
¹⁵Policy Formulation and Politics of Reform, Policy Implementation and Delivery of Services, Rule of Law, and Civil society and media (source: Addressing D & G challenges in the implementation of GHI, Sept. 2010)

APPENDIX I ACRONYMS

ACT	Artemisinin Combination Therapy
AIDS	Acquired Immune Deficiency Syndrome
AMTSL	Active Management of the Third Stage of Labor
ANC	Antenatal Care
ARV	Antiretroviral
BCC	Behavioral Change Communication
CAF	Country Assistance Framework
CBD	Community Based Distribution
CCM	Country Coordinating Mechanism
CDC	Centers for Disease Control and Prevention
CDRs	Centrales de Distribution Régionales (Regional Distribution Centers)
C-IMCI	Community Integrated Management of Child Illness
CODESA	Comité de Développement et de Santé (Development and Health Committee)
COP	Country Operational Plan
COSAs	Comité de Santé (Health Committee)
CPA	Complementary Package of Activities
DEP	Ministry of Health and the Directorate of Planning
DFID	The Department For International Development
DG	Democracy and Governance
DHS	Demographic and Health Survey
DOD	The Department of Defense
DOS	The Department of State
DOTS	Directly Observed Therapy
DRC	Democratic Republic of Congo
ENC	Essential Newborn Care
EU	European Union
FBO	Faith-Based Organizations
FEDECAME	Fédération des Centrales d'Approvisionnements en Médicaments Essentiels (Federation of Essential Medicine Procurement Agencies)
FP	Family Planning
GAVI	The Global Alliance for Vaccines and Immunization
GDRC	Government of the Democratic Republic of Congo
GHI	Global Health Initiative
GIBS	Group Inter-Bailleurs Santé / Health Donor Coordinating Group
GRH	General Referral Hospital
HIV	Human Immunodeficiency Virus
HSS	Health System Strengthening
HZ	Health Zone
IMCI	Integrated Management of Childhood Illness
ITNs	Insecticide Treated Nets
IPTp	Integrated Preventive Treatment for Pregnant Women
IUD	Intrauterine Device

KOICA	Korean International Cooperation
LAM	Lactational Amenorrhea Methods
LLIN	Long Lasting Insecticidal Nets
MCH	Maternal and Child Health
MDGs	Millennium Development Goals
MICS	Multiple Indicator Cluster Survey
MDR-TB	Multi-drug Resistant Tuberculosis
MNCH	Maternal, Newborn, and Child Health
MOH	Ministry of Health
MPA	Minimum Package of Activities
NGO	Nongovernmental Organizations
NMCP	National Malaria Control Program
NTDs	Neglected Tropical Diseases
OI	Opportunistic infections
OP	Operational Plan
ORS	Oral Rehydration Salts
OVC	Orphan and Vulnerable Children
PEPFAR	The President's Emergency Plan for AIDS Relief
PHC	Primary Health Care
PLWHA	People Living with HIV/AIDS
PMI	the President's Malaria Initiative
PMTCT	Prevent of Mother-to-Child Transmission
PNAM	Programme National d'Approvisionnement en Médicaments Essentiels (National Essential Medicine Supply Program)
PND	Plan National de Développement Sanitaire (National Health Development Plan)
PNS	Programme National de Lutte de SIDA (National AIDS Control Program)
PNMLS	Programme National Multisectoriel de Lutte contre le Sida (National Multi-Sector Programme)
PSN	Plan Stratégique National (National Strategic Plan) HIV/AIDS
RBF	Results Based Financing
RDT	Rapid Drug Tests
RH	Reproductive Health
SBCC	Social and Behavioral Change Communication
SNN	Stratégie Nationale sur la Nutrition pour les Nourrissons, les Enfants, et les Femmes en RDC (National Nutrition Strategy for infants, children, and women in DRC)
TB	Tuberculosis
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USG	United States Government
VCT	Voluntary Counseling and Testing
WASH	Water, Sanitation and Hygiene
WB	World Bank
WGGE	Women, Girls, and Gender Equality
WHO	World Health Organization

APPENDIX II GHI Results Framework



APPENDIX III Health Outcome Targets to be Achieved via GHI

Health Outcome Targets to be Achieved via GHI

As part of investing in country-led plans, GHI will support the GDRC to meet the national goals outlined in the PDNS.¹⁶ While these goals are ambitious, by working together with the GDRC and other donors, the USG hopes that the activities outlined in the GHI strategy will contribute to the following outcomes:

HIV/AIDS: The USG supports HIV/AIDS activities through a 'Partnership Framework' developed in support of the GDRC's National Strategic Plan (PSN) (2009-2014). Under PEPFAR the GDRC and USG took a strategic approach to identify the priority areas of the PSN to be supported under the partnership. Through the GHI strategy, USG activities support the GDRC efforts to meet the following three goals: reduction of STI & HIV transmission; increase the percentage of people with advanced HIV infection enrolled in ART; and increase the percentage of OVC in households receiving external support.

Targets:

- To halve the number of new HIV infection from 181,000¹⁷ to 90,500 by 2014;
- To increase the number of individuals in treatment: from 43,878¹⁷ to 148,000 by 2014;
- To increase the number in care from 60,000¹⁶ to 238,744 by 2014; and
- To increase the number of OVC in households receiving external support from 110,831¹⁷ to 657,000 by 2014.

Malaria: Under the GHI strategy, USG activities support the National Malaria Strategic Plan to reduce malaria prevalence and mortality rate by 50 percent of the baseline. Due to the additional expansion of HZs, and USG assistance to provide universal coverage of nets in Katanga, Maniema, and Orientale provinces, a significant reduction in malaria morbidity and mortality can be expected within two years if results from other PMI countries are representative.

Targets:

- To reduce the malaria mortality from 33.86 per 100,000 to 17 per 100,000 by 2015;
- To reduce the malaria prevalence among under-five children from 29.3 percent to 15 percent by 2015;
- To increase the percent of households with at least one ITN from nine percent to 100 percent by 2015;
- To increase the percent of women receiving at least two doses of IPTp from five percent to 85 percent by 2015; and
- To increase the percent of children under-5 with fever in the last two weeks of receiving artemisinin combination therapy (ACT) in less than 24 hours from 1 percent to 85 percent by 2015.

¹⁶The GHI targets are national targets.

¹⁷2009 estimate data

Maternal Health: Activities in the GHI strategy support the National Roadmap to Accelerate the Reduction of Maternal Mortality. The USG, in concert with other development partners, will reduce maternal mortality from 549 per 100,000 live births to 322 per 100,000 live births.

Targets:

- To increase the percentage of deliveries with skilled birth attendants from 80 percent to 90 percent by 2015;
- To increase the percentage of women with four ANC visits from 47 percent to 55 percent by 2015;
- To provide AMTSL for 90 percent of women during delivery by 2015; and
- To increase C-Sections for obstetric emergencies from 4 percent to 10 percent by 2015.

APPENDIX IV WGGE Activities under GHI

The following elements of the Women, Girls, and Gender Equality Principles are highlighted through current and future programming under the DRC/GHI strategy:

Ensure equitable access to essential health services at facility and community levels: USG

interventions focus on the rehabilitation and strengthening of the health system by making basic quality health care services available, with a particular emphasis on women through increased access to and quality of MNCH, FP/RH services. Examples include: gender consideration in the design of behavior change communication (BCC) messaging, the identification of program beneficiaries, community workers, program trainees and fellowship recipients, and WASH activities to increase access to potable water—thereby allowing more women the opportunity to explore income-generating opportunities and girls to attend school. Program activities will also seek to integrate men into FP, MNCH, and PMTCT activities. New activities implemented through the GHI strategy that seek to strengthen human resources for health will increase the number of available personnel, increase the skill levels of those personnel, and increase the resources available to women and girls. In addition, programs that focus on strengthening the supply chain will increase the availability and variety of health commodities utilized as a result of focusing on women, girls, and gender equality.

Monitor, prevent and respond to gender-based violence: The USG has been a major donor in the response to widespread SGBV in DRC. Throughout the GHI strategy, the USG seeks to find ways to integrate SGBV activities through a whole of government approach to promote protection, community prevention of and response to SGBV. This effort includes funding for fistula treatment, care, and support at six hospitals and providing medical and psychosocial support for SGBV survivors. Also, recently PEPFAR provided additional funding to DRC to integrate SGBV and HIV/AIDS activities, specifically to scale-up HIV-services, including post rape services, to SGBV survivors. USG programs are also strengthening the capacity at the national level by working to finalize the national protocol for the clinical care for sexual assault survivors. Once this protocol is finalized, USG Health, Social Protection and PEPFAR projects will help ensure roll-out and understanding of the protocol at all levels of the health system.

USG activities seek to engage women and girls to promote gender equitable participation in health: PEPFAR is using a comprehensive continuum of care approach that includes: behavior change communication (both mass media and interpersonal communication), condom social marketing, and HTC—including integrated HTC with FP services in community, standalone and mobile sites. BCC activities are also a part of USAID’s social marketing program, which uses peer-to-peer and mass media campaigns and the engagement of community leaders and church organizations to address gender related and other cultural barriers to FP promotion and acceptance. In addition, programs are using community health workers in a variety of ways to provide health messaging to improve the health of women and girls, and promote gender equality at the community level. Community health workers promote behavior change communication strategies to inform women and their entire family on FP use, the health benefits of timing, spacing or limiting pregnancies, and address FP rumors. BCC activities are being implemented during the post-partum period to engage husbands and grandmothers during the postpartum time on the use of FP and other important child and maternal health interventions.

APPENDIX V USG/DRC GHI INDICATORS¹⁸

HIV/AIDS

1. **PEPFAR:** Number of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission (**source: COP APR & SNIS**)
2. **PEPFAR:** Number of eligible clients who received food and/or other nutrition services (**source: COP APR & SNIS**) (*Disaggregated by age and gender*)
3. **PEPFAR:** Percent of adults and children known to be alive and on treatment 12 months after initiation of antiretroviral therapy (**source: COP APR & SNIS**) (*Disaggregated by age and gender*)

Malaria

4. **GHI:** Proportion of households with at least one ITN (**source: DHS 2012 & MICS 2014**)
5. **GDRC:** Proportion of women who have completed a pregnancy who have received two or more doses of IPTp (**source: DHS 2012; MICS 2014; & SNIS**) (*Disaggregated by age*)

TB

6. **WHO:** Treatment success rate (**source: WHO**)
7. **GHI:** Number of new multi-drug resistant TB patients diagnosed and initiated on treatment (**source: WHO**) (*Disaggregated by gender and age*)

Maternal Health

8. **GHI:** Percent of births attended by a skilled birth attendant (**source: DHS 2012; MICS 2014; & SNIS**) (*Disaggregated by gender*)

Child Health

9. **GHI:** Percent of children who received DPT3 by 12 months of age (**source: DHS 2012; SNIS; & UNICEF**) (*Disaggregated by gender*)
10. **GDRC:** Number of children <59 months who received IMCI protocol for treatment of fever, pneumonia, and diarrhea (**source: SNIS**) (*Disaggregated by gender*)

Nutrition

11. **GDRC:** Prevalence of wasting in children under 5 years (**source: SNIS; NAC; & DHS 2012**) (*Disaggregated by gender*)

Family Planning

12. **GHI:** Modern contraceptive prevalence rate (**DHS2012; MICS 2014; and SNIS**)

Human Resources for Health

13. **CUSTOM:** Number of health professionals trained with USG resources—*information to be separated by trained through the Leadership and Development Program and Kinshasa School of Public Health and by gender*
14. **CUSTOM:** Number of health workers who graduated from pre-service training institutions with support from USG resources. (*Disaggregated by type of health worker, gender*).¹⁹

¹⁸These are the GHI Indicators agreed upon by the GDRC and USG. Progress will be measured using these indicators to determine if GHI is meeting its goals. These indicators were chosen from the GDRC list of 63 health indicators, the GHI Indicator Handbook, and other USG documents. The custom indicators were designed to monitor progress of the three cross-cutting areas. If the source for the data is DHS/MICS/SNIS/WHO then the indicators are national. PEPFAR indicators with a source from the COP are generated by USG partners.

¹⁹ The NEPI program is expected to increase certain types of health workers such as mid-wives which are in short supply in DRC.

Supply Chain Management

15. **CUSTOM:** Can FEDECAME procure and deliver drugs in a timely manner? ²⁰
16. **CUSTOM:** Capacity to complete an order in 6 to 8 months (from the time the order is confirmed time to the time the goods are delivered in the warehouse (management))
17. **CUSTOM:** Availability of **all** sentinel medicines at all times (Target: >95%) (availability of products)
18. **CUSTOM:** Number of substandard/non-compliant products found in the consignment coming from prequalified sources (Target 0) (quality control)

Results Based Financing

19. **CUSTOM:** The number and percent of children who received DPT3 in RBF supported HZs compared to non-RBF HZs (*Disaggregated by sex*)
20. **CUSTOM:** Number of ITNs distributed to at-risk populations in RBF supported HZs compared to non-PBF HZs
21. **CUSTOM:** Completion rate of performance evaluations by level and by facility/office

²⁰ All the custom indicators referring to FEDECAME (a local NGO identified by the GDRC to procure and warehouse drugs) are indicators that must be achieved by FEDECAME. USAID will provide direct funding to this entity to test its capability to procure drugs and other medical supplies in a timely fashion, respecting USAID rules and regulations.

APPENDIX VI GHI Matrix

Democratic Republic of Congo Global Health Initiative Matrix

Focus Area #1: Strengthened Human Resources for Health.

Supports the National Program Results: By 2015, increase by 30% the population coverage receiving quality health care and services.

HRH MOH specific approach: i) reinforce health training at university levels, ii) efficient utilization of HRH; iii) improve the work and social conditions for health workers.

2015 GHI goal (globally)	Relevant National/ Ministry of Health Priorities/Initiatives & Baseline Information and DRC GHI Targets	Key Priorities/Activities	DRC GHI Indicators ²¹	GHI principles	Key Partners
<p>Overall GHI Goal (HIV/AIDS Prevention): Support the prevention of more than 12 million new infections</p> <p>Overall GHI Goal (HIV/AIDS Care): Support care for more than 12 million people, including 5 million orphans and vulnerable children</p> <p>DRC Specific Goal (HIV/AIDS): Reduction of STI &</p>	<p>Reference Documents: PNMLS aims to:</p> <p>Create a policy environment to facilitate the implementation of quality HIV/AIDS programs</p> <p>Prevent 500,000 new infections by 2014</p> <p>Provide counseling and testing to more than 23 million people by 2014</p> <p>Enroll 148,000 people on ART by the end of 2014</p> <p><u>GDRC Indicators</u> New HIV infection per</p>	<ul style="list-style-type: none"> • Dissemination and training of the HIV/AIDS and FP curriculum for health providers • Integration of GBV awareness and prevention into PMTCT sites • Providing national and provincial level support to a GBV taskforce and working with the government to establish policies integrating HIV into GBV activities and vice versa • Health worker pre-service and in-service training and supervision for HIV/AIDS services and 	<p>- <i>PEPFAR</i>: Number of HIV-positive pregnant women who receive ARV to reduce risk of mother to child transmission (source: COP APR)</p> <p>- <i>PEPFAR</i>: Number of eligible clients who received food and/or other nutrition services (source: COP APR)</p> <p>- <i>PEPFAR</i>: Percent of adults and children known to be alive and on</p>	<p>Focus on WGGE by expanding PMTCT coverage</p> <p>The GHI strategy encourages country ownership and plans, as it is in line with the PNLs 2011-2015 national plan</p> <p>Strengthening and leveraging public-private partnerships and engagement by strengthening the capacity of businesses to provide services to their surrounding community.</p>	<p>Global Fund DFID, UNAIDS, WHO, UNICEF, UNDP, MONUSCO, Health Zones, international NGOs, civil society, Kinshasa School of Public Health, American universities, Nursing Association, PLWHA Associations</p>

²¹ These are the GHI Indicators agreed upon by the GDRC and USG. Progress will be measured using these indicators to determine if GHI is meeting its goals. These indicators were chosen from the GDRC list of 63 health indicators, the GHI Indicator Handbook, and other USG documents. The custom indicators were designed to monitor progress of the three cross-cutting areas.

<p>HIV transmission</p> <p>Increase percentage of people with advanced HIV infection enrolled in ART</p> <p>Increase percentage of OVC in households receiving external free support</p>	<p>year</p> <p>Baseline: Current estimate (2009): 181,000 Target (2014): 90,500</p> <p>Number in care: Baseline: Current estimate: 60,000 Target (2014): 238,744</p> <p>Number of OVC receiving quality services: Baseline: Current: 110,831 Target (2014): 657,000</p>	<p>leveraging opportunities for integration</p> <ul style="list-style-type: none"> • Nursing Education Partnership Initiative (NEPI) incorporates HIV/AIDS patient management courses • Integration of HIV/AIDS and SGBV into basic training for military • Scholarships for School of Public Health in Kinshasa • Build capacity of the Freeport-McMoRan foundation to expand HIV services to the mining communities 	<p>treatment 12 months after initiation of ART (source: COP APR)</p> <p>- <i>PEPFAR</i>: Number of health workers who graduated from pre-service training institutions (source: COP APR)</p>		
<p>Overall GHI Goal (Malaria): Halve the burden of malaria for 450 million people, representing 70% of the at risk populations</p> <p>DRC Specific Goal (Malaria): 50% reduction in malaria burden (morbidity and mortality) in at-risk populations</p>	<p>Reference Documents: GDRC's National Health Development Plan and National Malaria Control Strategy (2011-2015):</p> <p>Reduce malaria morbidity and mortality by 50%</p> <p>Support to 112 health zones by 2012 and to 136 health zones by 2015</p> <p>100% of households in target areas have, on average, three LLINs;</p> <p>80% of pregnant women have access to IPTp</p>	<p>Capacity building of health workers in the following:</p> <ul style="list-style-type: none"> • Revision of pre-service courses related to malaria case management for use at medical and nursing schools • Support in-service training of health workers responsible for severe and uncomplicated malaria • Supervision of health workers trained in case management intervention to monitor performance and ensure quality of care • Conduct pilot of pre- 	<p>- <i>GHI</i>: Proportion of households with at least one ITN (source: DHS 2012 & MICS 2014)</p> <p>-<i>GDRC</i>: Proportion of women who have completed a pregnancy who have received two or more doses of IPTp (source: DHS 2012; MICS 2014; & SNIS)</p>	<p>Strategic integration, PMI is intensifying its efforts to build in-country capacity and integrate malaria activities with other USG programs</p> <p>Encourage country ownership and invest in country-led plans The MOP reflects national priorities and policies as described in the National Development Plan</p> <p>PMI supports revitalization of the</p>	<p>MOH National Programs, Global Fund, World Bank, PMI, WHO, UNICEF, Belgian Cooperation, Canadian Cooperation, DFID, UNDP, KOICA</p>

	<p>80% LLIN utilization</p> <p><i>GDRC Indicators</i> Malaria mortality (facility survey): Baseline: 33.86/100,000 (NMCP report 2010) Target: 17/100,000</p> <p>Malaria prevalence among under-five years children Baseline: 29.3% (DHS 2007) Target (2015): 15%</p> <p>Households with at least one ITN: Baseline: 9% & 51% (DHS 2007 & MICS 2010) Target (2015): 100%</p> <p>Women receiving at least 2 doses of IPTp: Baseline: 5% (DHS2007) Target (2015): 85%</p> <p>Children ≤5 with fever last 2 weeks receiving ACT in less than 24 hours Baseline: 1% (DHS 2007) Target (2015): 85%</p>	<p>referral treatment at community level to inform program strategies and improve quality of care</p> <ul style="list-style-type: none"> • Training of community health workers in early and appropriate treatment seeking behavior 		<p>National Referral labs in malaria diagnosis and entomology, thereby strengthening health systems and providing opportunities for training in data management</p> <p>Improving metrics and monitoring and evaluation by contributing to DHS</p> <p>Focus on women, girls, and gender equality: PMI will continue to support IEC strategies to encourage adoption of preventive behaviors and appropriate treatment among pregnant women and young children</p>	
<p>GHI goal: (maternal health) Reduce maternal</p>	<p>Reference Documents: The Roadmap to Accelerate the Reduction</p>	<ul style="list-style-type: none"> • Improve the capacity of health workers to identify early danger signs for 	<p>- <i>GHI:</i> Percent of births attended by a skilled birth</p>	<p>Women, girls and gender equality: Contribute to</p>	<p>MOH; Ministry of Gender;</p>

<p>mortality by 30% across countries</p> <p>GDRC Specific Goal: Contribute to reduce maternal mortality from 549/100,000 live births in 2007 to 322/100,000 live births in 2015</p>	<p>of Maternal and Neonatal Mortality, MOH, and PNSR 2008</p> <p>The government has prioritized the application of policy, norms and training guidance to support</p> <p>Increase availability and access of quality maternal and newborn healthcare services, including FP</p> <p><i>GDRC Indicators</i></p> <p>Deliveries with skilled birth attendants Baseline: 80% (DHS 2007) Target (2015): 90%</p> <p>Percentage of women with 4 ANC visits Baseline: 47% (DHS 2007) Target (2015): 55%</p> <p>C-sections for obstetric emergencies Baseline: 4%(DHS 2007) Target (2015): 10%</p> <p>AMTSL is provided to 90% of women during delivery</p>	<p>timely and appropriate emergency obstetric care.</p> <ul style="list-style-type: none"> • Improve the capacity of health workers to provide quality services during pregnancy, delivery and post-partum with a focus on labor monitoring, C-section, prevention of PPH with AMSTSL, management of pre-eclampsia/eclampsia, and appropriate post-abortion care • Expand support for fistula prevention and treatment by promoting sensitization of the issue, use of partographs for prevention and training in fistula repair 	<p>attendant (<i>source: DHS 2012; MICS 2014; & SNIS</i>)</p>	<p>improving women leadership in the health sector by increasing the number of women trained at the KSPH</p> <p>Country ownership: Contribute to accelerate the reduction of maternal mortality by supporting the national roadmap in the covered geographical areas</p> <p>Leverage other efforts: Partner with WHO, UNICEF & UNFPA in expanding and strengthening obstetrical care, including emergencies</p> <p>Coordination & integration: The MOH and its partners have agreed on a minimum package of maternal health interventions to be provided at the health center level</p> <p>Learning & accountability: the</p>	<p>women and family at central as well as provincial levels; local CBOs, FBOs, and NGOs; local women’s associations; medical and nursing teaching schools; WHO; UNICEF; UNAIDS; UNFPA</p>
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				systematic audit of maternal deaths	
<p>Overall GHI goal: (Child Health) Reduce Child Mortality rates by 35%</p> <p>GDRC Specific Goal: Contribute to reduce under-five mortality from 148/ 1000 live births in 2007 to 60/ 1000 live births in 2015</p>	<p>Reference Documents: PRSP, PNDS, Roadmap to Accelerate the Reduction of Maternal and Neonatal Mortality, EPI, IMCI & Nutrition Strategic Plans Childhood Illnesses, National Infant, Young Child and Maternal Nutrition Strategy</p> <p>GDRC Indicators <i>Integrated Childhood Illness:</i> Increase the percentage of children treated for pneumonia Baseline: 21% Target (2015): 41% and diarrhea Baseline: 31% (DHS 2007) Target (2015): 51%</p> <p>Exclusive breastfeeding Baseline: 36% (DHS 2007) Target (2015): 80%</p> <p>Vitamin A supplementation for children aged 6-59 months Baseline: 67% (SNN 2008) Target (2015) 80%</p> <p>Increase proportion of</p>	<p>Childhood Illnesses:</p> <ul style="list-style-type: none"> • Ensure adequate training of health workers to improve the quality of integrated management of childhood illnesses (IMCI) • Provide supervisory training and on the job aids for supporting IMCI • Expand case management training of community workers to include treatment/referral of diarrhea, pneumonia, malaria, plus detection and referral of child malnutrition <p>Nutrition:</p> <ul style="list-style-type: none"> • Improve the capacity of health workers and community relays to apply the new Infant and Young Child Feeding (IYCF) protocol <p>Immunizations:</p> <ul style="list-style-type: none"> • Identify and strengthen the capacity of health workers in providing routine immunizations and surveillance. 	<p>-GHI: Percent of children who received DPT3 by 12 months of age (source: DHS 2012; SNIS; & UNICEF)</p> <p>- GDRC: Number of children <59 months who received IMCI protocol for treatment of fever, pneumonia, and diarrhea (source: SNIS)</p> <p>- GDRC: Prevalence of wasting in children under 5 years (source: SNIS; NAC; & DHS 2012)</p>	<p>Women, girls and gender equality: In the 80 USG-assisted HZs, provide nutrition activities, reach women and girls of all socioeconomic and education levels, and promote equal access to a balanced diet for men/boys and women/girls as a priority</p> <p>Encourage country ownership and invest in country-led plans: USG-supported child health activities align with the new PNDS 2011-2015 priorities</p> <p>Contribute to improve the institutional capacities of PRONANUT to coordinate with donors and implementing partners and to advocate for increased resources</p> <p>Strengthen and leverage other efforts: Partner with WHO &</p>	<p>Ministries (Planning; Health; Gender, Women and Family; Education; Agriculture & Rural Development; Energy; and Environment at central provincial and local levels); medical and nursing teaching schools; local CBOs, FBOs , and NGOs; WHO; UNICEF; UNAIDS; UNFPA</p>

	<p>children completely vaccinated</p> <p>Baseline: 31% (DHS 2007)</p> <p>Target (2015): 55%</p>	<ul style="list-style-type: none"> • Build the capacity of health workers and supervisors to support the introduction of new vaccines 		<p>UNICEF in expanding IMCI, ENC and immunizations</p> <p>Partner with UNICEF and ECHO to complement interventions in geographical areas where malnutrition rates are very high (Lodja, Lomela, Luiza health zones)</p> <p>Increase impact through strategic coordination and integration: The MOH and partners (including USG) have agreed on a minimum package of child health interventions to be provided at the health center level</p>	
<p>Overall GHI goal: (Family Planning) Prevent 54 million unintended pregnancies.</p> <p>GDRC Specific Goals: Contribute to reduce maternal mortality from 549/</p>	<p><i>(Please see reference to priorities under maternal health; the MOH categorizes FP under maternal health)</i></p> <p>Strengthen the capacity to plan, implement, monitor and evaluate FP activities at national, provincial, health zone and community level</p>	<ul style="list-style-type: none"> • Increase the number of service providers and improve their capacity to deliver quality FP/RH/HIV/AIDS services through on-the-job and participatory methods of training • Increase the number of community based 	<p>- <i>GHI:</i> Modern contraceptive prevalence rate (DHS2012; MICS 2014; and SNIS)</p>	<p>Focus on women, girls and gender equality: The current FP/RH program's BCC efforts foster men's support to reduce barriers to access modern contraceptive methods as a way to promote the principle of women, girls, and</p>	<p>Ministry of Health, MoH's national programs, UNFPA, World Bank, DFID, WHO</p>

<p>100,000 live births in 2007 to 322/100,000 live births in 2015.</p> <p>Increase Contraceptive prevalence rate from 6% to 15%</p>	<p>Increase access to quality FP services. Increase advocacy for further political commitment & more resources for MCH & FP</p> <p>Increase community empowerment and community based services</p> <p><u>GDRC Indicators:</u> Increase contraceptive prevalence rate from Baseline: 6% (DHS 2007) Target (2015): 15%</p> <p>Increase Couple Years of Protection Baseline: 432,325 (FY09 Mission results) Target (2015): 700,000 in USG programs</p>	<p>distributors of FP methods</p> <ul style="list-style-type: none"> • Build on momentum from the National FP Conference through identification of new/mentoring current FP champions, and training them in evidence-based advocacy tools • Orient health workers on existing FP guidelines, norms, and tools • Training health workers on quality data collection for improved planning 		<p>gender equality.</p> <p>Strengthen and leverage other efforts: USG supports the country's effort to advocate for more resources for FP/RH and is working with other donors including UNFPA</p> <p>Build sustainability through HSS: Improve the country's capacity in HRH</p>	
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**Democratic Republic of Congo
Global Health Initiative Matrix**

Focus Area # 2: Improved Supply Chain Management System

PNDS promotes: i) availability of essential drugs in all health zones, ii) the coordination of procurement improved, iii) quality assurance system put in place, and iv) the capacity of health staff improved in SCM (forecasting, prescription)

2015 GHI Targets	Relevant National/ Ministry of Health Priorities/Initiatives & Baseline Information and DRC GHI Targets	Key Priorities/Activities	DRC GHI Indicators ¹⁹	Key GHI Principles	Key Partners
<p>Overall GHI Goal (HIV/AIDS Treatment): Provide direct support for more than 4 million on treatment</p>	<p>Enroll 148,000 PLWHA on ART by the end of 2014 <i>(source: PDNS)</i></p> <p><u>GDRC Indicator:</u> Number in treatment: Baseline: Current: 43,878 Target (2014): 148,000</p>	<p>Carry out activities to improve essential health commodity supply chains:</p> <ul style="list-style-type: none"> • Strengthening logistics management information systems • Streamlining distribution systems • Identifying financial resources for procurement and supply chain operation • Enhancing forecasting and procurement planning • Advocacy for policymakers and donors to support logistics as a critical factor in the overall success of their health care mandates • Adults, HIV-positive pregnant women, and children have access to ARVs • Government health facilities don't have stock outs of ARVs 	<p>-<i>PEPFAR:</i> Percent of adults and children known to be alive and on treatment 12 months after initiation of ART <i>(source: COP APR)</i></p> <p>- <i>PEPFAR:</i> Number of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission <i>(source: COP APR and SNIS)</i></p> <p>- <i>CUSTOM:</i> Can the FEDECAME system procure and deliver drugs in a timely manner</p> <p>- <i>CUSTOM:</i> Capacity to complete an order in</p>	<p>USG PEPFAR expansion into Kisangani will increase impact through strategic coordination and integration</p>	<p>Global Fund, DFID, UNAIDS, WHO, UNICEF, UNDP, MONUSCO, HZs, International NGOs, civil society, Kinshasa School of Public Health, American universities, Nursing Association, PLWHA Associations</p>

			<p>6 to 8 months (from the time the order is confirmed time to the time the goods are delivered in the warehouse (management))</p> <p>- <i>CUSTOM</i>: Availability of all sentinel medicines at all times (Target: >95%) (availability of products)</p> <p>- <i>CUSTOM</i>: Number of substandard/ non-compliant products found in the consignment coming from prequalified sources (Target 0) (Quality control)</p>		
<p>DRC specific Goal (malaria): 50% reduction in malaria burden (morbidity and mortality) in at-risk populations</p>	<p>Reference Documents: National Malaria Control Strategy (2011-2015):</p> <p>Universal access to diagnostic services</p> <p>80 percent of pregnant women have access to intermittent preventive treatment (IPTp)</p> <p>Strengthening of supply</p>	<p>Carry out activities to improve essential malaria commodity supply chains:</p> <ul style="list-style-type: none"> • Strengthening logistics management information systems • Streamlining distribution systems • Identifying financial resources for procurement and supply chain operation • Enhancing forecasting and procurement planning 	<p>-<i>GHI</i>: Proportion of households with at least one ITN (source: DHS 2012 & MICS 2014)</p> <p>- <i>GDRC</i>: Proportion of women who have completed a pregnancy who have received two or more doses of IPTp (source: DHS 2012; MICS 2014;</p>	<p>Strategic integration, PMI is intensifying its efforts to build in-country capacity and integrate malaria activities with other USG programs</p> <p>Encourage country ownership and invest in country-</p>	<p>MOH National Programs, Global Fund, World Bank, PMI, WHO, UNICEF, Belgian Cooperation, Canadian Cooperation, DFID, UNDP,</p>

	<p>chain management including end use verification.</p> <p>Also, see earlier stated malaria priorities and indicators on Focus area #1 for HRH.</p>	<ul style="list-style-type: none"> • Pregnant women have access to intermittent preventive treatment (IPTp) • LLINs available for priority groups of pregnant women and <5 children • Government health facilities don't have stock outs of key tracer drugs (ACT, IPTp) 	<p>& SNIS)</p> <ul style="list-style-type: none"> - <i>CUSTOM</i>: Can the FEDECAME system procure and deliver drugs in a timely manner - <i>CUSTOM</i>: Capacity to complete an order in 6 to 8 months (from the time the order is confirmed time to the time the goods are delivered in the warehouse (management) - <i>CUSTOM</i>: Availability of all sentinel medicines at all times (Target: >95%) (availability of products) - <i>CUSTOM</i>: Number of substandard/ non-compliant products found in the consignment coming from prequalified sources (Target 0) (Quality control) 	<p>led plans: The MOP reflects national priorities and policies as described in the National Development Plan</p> <p>Health systems strengthening: PMI is strengthening supply chain logistics</p> <p>Improving metrics and monitoring and evaluation: PMI is monitoring ACTs</p> <p>Focus on women, girls, and gender equality: PMI will continue its support of communication strategies to encourage the adoption of preventive behaviors and appropriate treatment among pregnant women and young children</p>	<p>KOICA</p>
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<p>Overall GHI goal (TB): Contribute to a 50% reduction in TB deaths and disease burden</p>	<p>Reference Documents: National Health Development Plan and TB strategy (2011- 2015):</p> <p>Decrease the TB mortality rate by 50%</p> <p>Increase TB detection rate to at least 70%</p> <p>Increase the success rate to 85%</p> <p><u>GDRC Indicators:</u> Case detection rate Baseline: 45% (WHO report 2010) Target (2015): 75%</p> <p>DOTS treatment success rate Baseline: 83% (2008) Target (2015): 90%</p> <p>New MDR cases treated Baseline: 176 cases of 1500 (WHO 2010) Target (2015): 220MDR cases/year treated by USG with an increase of 10% / year to reach 1349</p>	<ul style="list-style-type: none"> • Provide timely support to ensure that lab commodities and reagents are procured and available in USG supported central and provincial labs • Ensure that health workers, including lab technicians, are trained in supply chain management skills • Assess current TB drugs distribution system (transportation, storage, distribution) comparing the use of TB coordination offices for storage and the use of CDRs (Centre de distribution regional), which is a government distribution system • Assist the country in quantification and forecasting based on health zones' data rather than estimates to avoid underestimation leading to stock outs • Ensure better pharmaceutical data collection at operational level • Ensure that a TB drug buffer stock is available (including second line TB drugs) by procuring TB drugs-1st and 2nd line 	<ul style="list-style-type: none"> - <i>WHO:</i> Treatment success rate - GHI: Number of new multi-drug resistant TB patients diagnosed and initiated on treatment (<i>source: WHO</i>) - <i>CUSTOM:</i> Can the FEDECAME system procure and deliver drugs in a timely manner - <i>CUSTOM:</i> Capacity to complete an order in 6 to 8 months (from the time the order is confirmed time to the time the goods are delivered in the warehouse (management) - <i>CUSTOM:</i> Availability of all sentinel medicines at all times (Target: >95%) (availability of products) 	<p>Focus on women, girls, and gender equality: TB funds will continue to train and supervise healthcare providers at different levels with an emphasis on women professionals</p> <p>Health systems strengthening: USG TB funding will support rehabilitation of the National Referral labs in MDR TB at central level and in two provinces and strengthening the national TB program to better forecast needs and prevent stock outs</p>	<p>MOHPATH (TB 2015), WHO, MSH (IHP) UNION, Club des amis de Damiens, CARITAS, Foundation Damien</p>

			<p>- <i>CUSTOM</i>: Number of substandard/ non-compliant products found in the consignment coming from prequalified sources (Target 0) (Quality control)</p> <p>-</p>		
<p>Overall GHI goal: (Family Planning) Prevent 54 million unintended pregnancies</p>	<p>Reference Documents: Road Map to Accelerate the Reduction of Maternal and Neonatal Mortality</p> <p>Support efforts to improve management related to forecasting, procurement, inventory management, and drug management systems</p> <p>Also, see earlier stated FP priorities and indicators on Focus area #1 for HRH</p>	<ul style="list-style-type: none"> • Improve quantification, forecasting of SR commodities; • Ensure an effective supply chain management system is in place to prevent stock outs and FP commodities are available through the usual distribution in health facilities, at community level and social marketing sites. 	<p>-<i>GHI</i>: Modern Contraceptive prevalence rate (<i>DHS2012; MICS 2014; and SNIS</i>)</p> <p>- <i>CUSTOM</i>: Can the FEDECAME system procure and deliver drugs in a timely manner</p> <p>- <i>CUSTOM</i>: Capacity to complete an order in 6 to 8 months (from the time the order is confirmed time to the time the goods are delivered in the warehouse (management))</p> <p>- <i>CUSTOM</i>: Availability of all sentinel medicines at all times (Target: >95%)</p>	<p>Encourage country ownership and invest in country-led plans: USG will support the national FP agenda, i.e. provide support to FP/RH and fistula coordination efforts</p> <p>Strengthen and leverage other efforts: USG supports the country's effort to advocate for more resources for FP/RH and is working with other donors including UNFPA</p> <p>Build sustainability through HSS: Improve the country's capacity in supply chain</p>	<p>Ministry of Health, MoH's national programs, UNFPA, World Bank, DFID</p>

			(availability of products) - <i>CUSTOM</i> : Number of substandard/ non-compliant products found in the consignment coming from prequalified sources (Target 0) (Quality control)	management to prevent contraceptive stock outs	
Overall GHI Goal (Maternal Health): Reduce maternal mortality by 30% across countries	Reference Documents: The Roadmap to Accelerate the Reduction of Maternal Mortality, MOH, PNSR 2008 The government has prioritized the application of policy, norms and training guidance to support Increased availability and access of quality maternal and newborn healthcare services, including FP Also, see earlier stated maternal health priorities and indicators on Focus area #1 for HRH.	<ul style="list-style-type: none"> • Ensure availability and supply chain of potent oxytocin and include procurement and management of emergency obstetric drugs in Minimum and Complementary Package of services at appropriate levels • Ensure availability and supply chain of supplies and equipment at health facilities for emergency obstetrical care 	- <i>CUSTOM</i> : Can the FEDECAME system procure and deliver drugs in a timely manner - <i>CUSTOM</i> : Capacity to complete an order in 6 to 8 months (from the time the order is confirmed time to the time the goods are delivered in the warehouse (management) - <i>CUSTOM</i> : Availability of all sentinel medicines at all times (Target: >95%) (availability of products) - <i>CUSTOM</i> : Number of	Country ownership: Contribute to accelerate the reduction of maternal mortality by supporting the national roadmap in the covered geographical areas Leverage other efforts: Partner with WHO, UNICEF & UNFPA in expanding and strengthening obstetrical care, including emergencies Coordination & integration: The MOH and its partners have agreed on a	MOH; Ministry of Gender; women and family at central as well as provincial levels; local CBOs, FBOs, and NGOs; local women's associations; medical and nursing teaching schools; WHO; UNICEF; UNAIDS; UNFPA

			substandard/ non-compliant products found in the consignment coming from prequalified sources (Target 0) (Quality control)	minimum package of maternal health interventions & essential drugs to be provided at the health center level Sustainability through HSS: Contribute to strengthening the national essential medicines supply chain and training of MOH staff in HZs	
Overall GHI goal: (Child Health) Reduce child mortality rates by 35%	Reference Documents: PRSP, PNDS, Roadmap to Accelerate the Reduction of Maternal and Neonatal Mortality, EPI, IMCI & Nutrition Strategic Plans Childhood Illnesses, National Infant, Young Child and Maternal Nutrition Strategy	Childhood Illnesses: <ul style="list-style-type: none"> • Ensure availability and supply chain of essential medicines, material and equipment to adequately manage malaria, pneumonia, diarrhea and other childhood illnesses of public health importance Nutrition: <ul style="list-style-type: none"> • Ensure availability and supply chain of nutritional supplements to treat severe acute malnutrition in highly affected geographical areas such as Luiza, Lodja and Lomela • Ensure availability of vitamin A tablets, iron-folate tablets and mebendazole for deworming, equipment and material for 	<ul style="list-style-type: none"> - <i>CUSTOM:</i> Can the FEDECAME system procure and deliver drugs in a timely manner - <i>CUSTOM:</i> Capacity to complete an order in 6 to 8 months (from the time the order is confirmed time to the time the goods are delivered in the warehouse (management) - <i>CUSTOM:</i> Availability of all sentinel medicines at all times (Target: >95%) (availability of 	Encourage country ownership and invest in country-led plans: USG-supported child health activities align with the new PNDS 2011-2015 priorities Strengthen and leverage other efforts: Partner with WHO & UNICEF in expanding IMCI, ENC, nutrition and immunizations Partner with UNICEF and ECHO to complement interventions in	Ministries (Planning, Health; Gender, Women and Family; Education; Agriculture & Rural Development; Energy; and Environment at central provincial and local levels), medical and nursing teaching schools;

		<p>growth monitoring.</p> <p><i>Immunizations:</i></p> <ul style="list-style-type: none"> • Ensure availability of vaccines to prevent stock outs; syringes, cold chain equipment (including solar panel, fridges, cool boxes, and petrol) and safety boxes for the disposal of sharps waste <p><i>Newborn care:</i></p> <ul style="list-style-type: none"> • Ensure availability and supply chain of essential medicines and equipment needed for essential newborn care, including newborn resuscitation 	<p>products)</p> <p>- <i>CUSTOM:</i> Number of substandard/ non-compliant products found in the consignment coming from prequalified sources (Target 0) (Quality control)</p>	<p>geographical areas where malnutrition rates are very high (Lodja, Lomela, Luiza health zones)</p> <p>Increase impact through strategic coordination and integration: The MOH and its partners (including USG) have agreed on a minimum package of child health interventions to be provided at the health center level throughout the country</p> <p>Build sustainability: Child health funding will contribute to strengthening the national essential medicines supply chain management</p>	<p>CBOs; FBOs; NGOs; WHO; UNICEF; UNFPA</p>
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**Democratic Republic of Congo
Global Health Initiative Matrix**

Focus Area # 3: Results Based Financing

(This focus area supports the GHI principle focused on research and innovation. Under GHI, USG will be launching RBF work in the DRC in our IHP health zones)

2015 GHI Targets	Relevant National/ Ministry of Health Priorities/Initiatives & Baseline Information and DRC GHI Targets	Key Priority Actions	DRC GHI Indicators ¹⁹	Key GHI Principles	Key Partners
All the aforementioned GHI Impact Targets in HIV/AIDS, Malaria, Maternal Health, Child Health, FP, and TB will be addressed through RBF	MOH's Directorate of Studies and Planning (DEP) will launch the "national orientation document on RBF" and standardization of guidelines to operationalize RBF	<ul style="list-style-type: none"> • Orientation and training of health workers on RBF at central, provincial and health zone levels • Design and development of management tools, and drafting of the manual of procedures concerning RBF model • Adequate technical assistance is provided by training RBF project staff to support RBF in selected Integrated Health project sites 	<p><i>Indicators will be finalized in the near future. The proposed indicators include the following:</i></p> <ul style="list-style-type: none"> - <i>CUSTOM</i>: Number or percent of children who received DPT3 in RBF supported HZs compared to non-RBF HZs - <i>CUSTOM</i>: Number of ITNs distributed to priority populations (pregnant women, children under 5 years) in RBF supported HZs compared to non-RBF HZs - <i>CUSTOM</i>: Completion rate of performance evaluations by level and by facility/office. 	<p>Country ownership: Contribute to accelerate the reduction of maternal, infant and newborn morbidity and mortality by aligning with the PNDS principles</p> <p>Leverage other efforts: partnership with WHO, UNICEF & UNFPA and other donors</p> <p>Coordination & integration: The MOH and its partners agreed on a minimum/ complementary package of health interventions to be provided at the health center/hospital levels.</p>	MOH : (central, intermediate and operational levels), local NGOs, Global Fund, World Bank, EU, GTZ, CORDAID, Integrated Health Program

				<p>Sustainability through HSS: Contribute to strengthening the national essential medicines supply chain and training of MOH staff in HZs</p> <p>Learning & accountability: An evaluation of the impact of RBF on the quality of services provided will be conducted; the efficiency of FEDECAME to procure drugs to a limited number of health zones will be evaluated.</p> <p>Focus on women, girls, and gender equality: Under the integrated health program there is a focus to involve participation of women and girls in the design, implementation and evaluation of interventions</p>	
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