MCSP Democratic Republic of Congo
Strengthening MOH Institutional Capacity

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Background

USAID's flagship Maternal and Child Survival Program (MCSP) partnered with the Democratic Republic of Congo's Ministry of Public Health (MOH) from 2015 to early 2019 to accelerate reductions in maternal and child mortality. Strengthening the Ministry's institutional capacity to strategically scale up cost-effective, high-impact, evidence-based interventions was among MCSP's primary objectives at the national level. To do this, MCSP DRC worked with multiple MOH divisions, programs and national technical working groups (TWG) to update key policies, strategies and tools, build and better coordinate partnerships at provincial, zonal and local levels, and jointly track progress made toward key national health goals addressing the remaining gaps.

DRC's MOH is divided into thematic directorates, each responsible for a distinct area of health programing. MCSP's institutional capacity strengthening activities responded to the specific requirements of each MOH unit engaged in the collaboration, but our primary client at the national level was the Directorate of Family Health and Specific Groups (the D10). The D10 spearheads healthcare for women, children, newborns and adolescents and houses national programs for control of acute respiratory disease, cholera and other diarrheal diseases, immunization, family planning (FP), nutrition and others.

MCSP was in a unique position amongst DRC's health sector partners because of its work at the national level with the MOH's units and its simultaneous support to Tshopo and Bas-Uélé provinces for implementation of integrated child health, FP, nutrition and water, sanitation and hygiene (WASH) activities. MCSP's national and provincial presence allowed the program to contribute to the development of new policies, strategies and tools at national level and ground-truthing them through testing in the provinces before the MOH adopted them. This made it possible for MCSP to support the early roll out of many of the MOH's new and updated strategies and approaches in Tshopo and Bas-Uélé provinces with their respective provincial health offices known as the *Division Provincial de la Santé* (DPS).

Targeted MOH Units

- Directorate of Family Health and Specific Groups **(D10)**
  - National Program for the Control of Acute Respiratory Diseases **(PNIRA)**
  - National Program for the Elimination of Cholera and other Diarrheal Diseases (**PNECHOLMD,** formerly the PNLMD)
  - National Reproductive Health Program (**PNSR**)
  - National Program of Nutrition (**PRONANUT**)
  - Reproductive, Maternal, Newborn, Child, and Adolescent Health **(RMNCAH)** Task Force
- General Directorate for the Organization and Management of Health Services (**DGOGSS)**
  - Directorate for Primary Health Care Development (**D5**) and its Division of National Health Information Systems **(DSNIS)**
- Directorate of Continuing Education **(D11)**
- Directorate of Studies and Planning **(DEP)**
- Directorate of Hygiene **(D9)**

Results by MOH Division or Program

Directorate of Family Health and Specific Groups and the RMNCAH Task Force

D10 organizational capacity building plan developed. In April 2017, MCSP and D10 used the Participatory Institutional Capacity Assessment and Learning Index (PICAL) developed by USAID to determine D10's organizational needs. The results informed a capacity building plan, which was subsequently reflected in the Directorate's 2018-2022 strategic plan. The PICAL exercise highlighted gaps in training and the need for annual operational planning. A significant restructuring of the MOH, including replacement of the director of the D10, occurred in early 2018. MCSP quickly established a strong working relationship with the Directorate's new leadership and was able to use the PICAL results to ensure that strengthening of the D10, itself, became one of the new leadership's priorities. In this instance, MCSP collaborated with Health Financing and Governance, another USAID implementing partner to strengthen further the D10's institutional capacity by offering its management team training on results-based management and strategic planning.

Annual Operational Plans (AOP) developed and implemented. MCSP supported the D10, the national Acute Respiratory Infection and Integrated Community Case Management Program (PNIRA) and Cholera and Other Diarrheal Diseases Control Program (PNECHOLMD) to develop their AOPs in both 2017 and 2018. As a result of MCSP's support, for the first time in 2017 these D10 programs and divisions had AOPs that were aligned with the National Health Development Plan and costed to reflect identified sources of funding and funding gaps. Costed AOPs served as an advocacy tool that helped mobilize needed resources from other partners, including WHO, UNICEF, and USAID implementing partners such as Prosani Plus.

National Reproductive, Maternal, Newborn, Child, and Adolescent Health Task Force (RMNCAH TF) revitalized. The RMNCAH TF was first established by the D10 in 2012 to coordinate stakeholders at all levels and promote joint action to improve RMNCAH outcomes. During its early period, the RMNCAH TF organized quarterly meetings that included D10 programs, other MOH divisions, other ministries, international partners, civil society and private actors. The RMNCAH TF had become inactive prior to MCSP's arrival in March 2016. MCSP therefore worked with D10 leadership to revitalize the RMNCAH TF, and with WHO, Pathfinder, Cuso International, UNICEF, Prosani Plus and others to organize three high-profile RMNCAH TF meetings (December 2016, February 2017 and June 2017). The Secretary General of Health presided over these meetings, which had over 100 participants at each including representatives from three ministries (Interior, Family and Gender, Education), civil society, the National Senate and all key international donor agencies and partners. In addition to providing technical support, MCSP along with other partners (WHO, UNICEF and Prosani Plus) managed meeting logistics and helped the D10 to keep the momentum going by preparing meeting reports and tracking follow-up on agreed upon actions.

In June 2018, the Minister of Health elevated the RMNCAH TF, renaming it the RMNCAH Platform, and putting it directly under his purview. Although technical coordination continues with D10, the Minister's Office has developed a new scope of work for the RMNCAH Platform as well as a Ministerial decree to officially create it. These two documents had been finalized when MCSP closed out; the expectation was that they would be signed by the incoming MOH leadership.

Provincial RMNCAH TF activated in Tshopo and Bas-Uélé provinces. D10's 2017 AOP included plans to revitalize the RMNCAH TF in Tshopo province. Established by the DPS in 2013, the provincial RMNCAH TF was no longer active by the time MCSP entered the province in 2016. MCSP supported the D10 to orient the DPS on the functions of a provincial RMNCAH TF and then coordinated a meeting in Tshopo to re-establish the RMNCAH TF and confirm its members. Bas-Uélé province, where MCSP also worked, had no pre-existing Task Force, so MCSP helped the DPS to establish a new group in the provincial capital, Buta, and provided the same coordination and technical and financial support as in Tshopo. The Bas-Uélé DPS assumed the leadership of its Task Force with co-facilitation from MCSP and ongoing technical and financial support from the D10 and its programs and partners including the National Nutrition Program (PRONANUT), Sanru (the Global Fund for TB, Malaria and AIDS implementing agency) and others. The two provincial Task Forces coordinated the production of integrated RMNCAH plans with the contribution of all provincial stakeholders and partners. In addition, TF members were active in field activities that included joint supervision and data validation meetings at the health zone and provincial level.

RMNCAH policies and standard operating procedures (SOPs) rolled out. Finalized in 2012, important national RMNCAH policies and SOPs still had not been disseminated to the operational level (health zones and health centers) in 2017. MCSP promoted and disseminated printed copies of these policies and SOPs and, in June 2017, worked with national level facilitators to train ten provincial trainers from the Tshopo and Bas-Uélé DPS in the use of the SOPs. According to the strategy that the D10 recommended, these provincial trainers were expected to cascade their training to members of the health zone management teams and the zonal trainers were expected to deliver the same training to service providers at the health facility level. Because the cost of this cascade strategy was prohibitively high, MCSP worked with the DPS on a more pragmatic approach with a lower cost. This included taking advantage of existing opportunities such as adding two days to health zone data monitoring and validation meetings and working with the provincial trainers to provide orientation on the policies and SOPs. MCSP also promoted the use of joint supervision visits to do the same. As a result, health zone and health facility workers saw and used these important documents for the first time and many expressed their gratitude to the trainers for the opportunity. This positive experience was shared with the MOH and partners during a national RMNCAH coordination meeting. As a result, other USAID implementing partners adopted the same strategy to roll out the policies and SOPs with the DPS that they support.

Child Health Policies and Programs

DRC's Every Newborn Action Plan (ENAP) developed. DRC suffers from both high levels of maternal (846 maternal deaths/100,000 births) and neonatal mortality (estimated in 2017 at 28/1,000 live births)[1]. With an estimated 3,400,000 births and 98,000 neonatal deaths per year, DRC has the fourth highest number of newborn deaths globally, with only Pakistan, Nigeria and India experiencing larger numbers of annual newborn deaths[2]. Based on this high burden of neonatal mortality, DRC is one of the global ENAP focus countries; however, before 2016, there had been little country-level engagement with the global ENAP initiative. MCSP contributed technically and generated momentum by supporting the development and costing of a five-year DRC ENAP, thereby helping the Government of DRC add its commitment to the global effort to reduce newborn mortality. As part of the plan, MCSP supported the development of an ENAP roadmap, key messages, a leaflet and poster, and advocacy tools for resource mobilization that were used successfully at a UNICEF partners' roundtable to increase funding commitments for newborn health. MCSP also supported the dissemination of the ENAP package at national level and in Tshopo and Kongo Central provinces.

Updated iCCM Guidelines and Tools

MCSP worked with the CH Working Group to update 23 different iCCM tools:

- Implementation guidelines
- Individual sick child management form
- iCCM training modules for trainers, coaches, and CHW (relais)
- Data collection and reporting tools
- Counseling cards
- Instructional video
- iCCM indicators
- Monitoring and supervision tools

National Integrated Management of Newborn and Childhood Illness (IMNCI) strategy updated and TWG revitalized. DRC was an early adopter of IMNCI and of IMNCI's community component known as Integrated Community Case Management (iCCM). In 2003, a Ministerial order established the IMNCI TWG in charge of coordination and implementation of child survival activities under the national IMNCI Strategy. However, when MCSP began in 2015, the two national programs that drive IMNCI and iCCM in DRC-PNIRA (responsible for the facility-based clinical component) and PNECHOLMD (responsible for the community component)-were working separately. With MCSP's encouragement and technical assistance, the two bodies

1 DRC Demographic and Health Survey 2013/2014
2 Ref: HNN; https://www.healthynewbornnetwork.org

came together under the revitalized IMNCI TWG and started having regular meetings with partners. They successfully updated the National IMNCI Strategic Plan 2018-2022. The strategic plan includes both clinical and community IMNCI components and sets a number of ambitious goals that include, by 2022, contributing to at least a 40% reduction in under-five mortality and increasing by at least 60% the proportion of health facilities that have IMNCI and are providing quality health services to newborns and children. Approved in August 2017, the IMNCI Strategic Plan has become a useful tool in the effort to mobilize both domestic and donor resources for child health.

IMNCI Technical Working Group Members

MOH Directorates and Programs
D10, D11, PNIRA, PNECHOLMD, PRONANUT

Multilateral Partners
WHO, UNICEF, DFID

USAID Implementing Partners
MCSP, IHP plus, PMI, SANRU, PSI/ASF

Other
IRC

National Community Health Strategic Plan (2019-2022) finalized. MCSP supported the Directorate for Primary Health Care Development (D5) with the updating of this important national plan, which repositions the community as a leading partner, actor and beneficiary of all health interventions and services. It also recommends strengthening community structures and mechanisms to encourage effective community participation in the management of health services. MCSP's work to expand iCCM and strengthen the community module of the national Health Management Information System (HMIS) were all bolstered by the adoption of this new strategic plan.

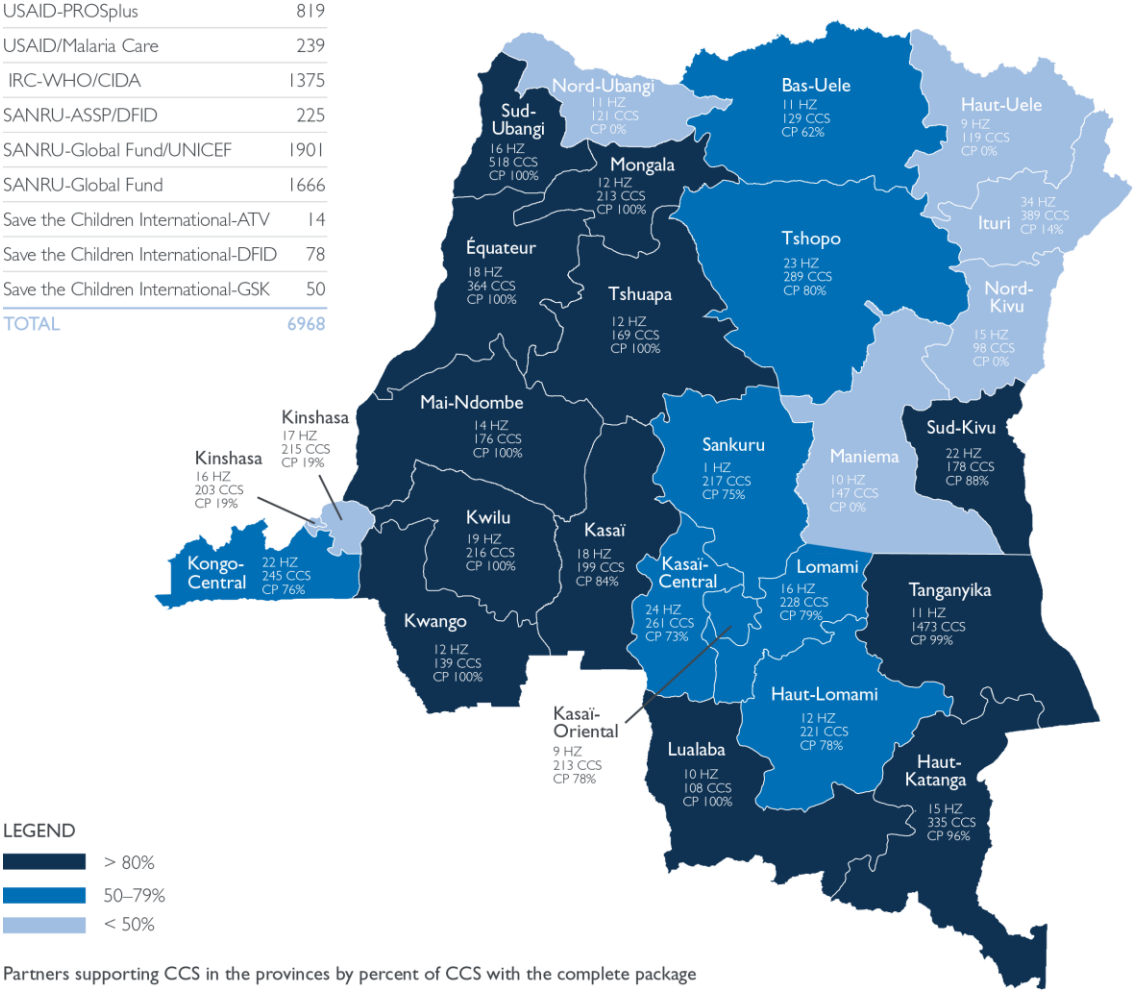
iCCM policy, guidelines, training packages and tools updated. In September 2016, MCSP worked with UNICEF and WHO, through the IMNCI TWG, to redesign and then test updated iCCM policies and tools. Updated materials incorporate recent evidence and added visuals meant to facilitate use and understanding by lower-literacy, *Relais Communautaire (*community health workers). Thereafter, MCSP and partners, supported the MOH to train 34 central level staff as trainers on the updated iCCM materials. MCSP mobilized a number of these national trainers to initiate cascade training with the DPS of Tshopo and Bas-Uélé providers. This resulted in health providers at 106 health centers and *Relais Communautaire* from 119 community care sites being trained. Also, other partners, including Prosani Plus, Save the Children and Sanru, used these tools to train facility and community health workers in the zones that they support.

iCCM/IMNCI sites mapped and needs quantified. MCSP developed an electronic map that can be used to monitor real-time changes in the numbers of community care sites providing iCCM services nationwide, their geographic distribution, the populations served, services offered, and implementing partners involved. Following data validation and cleaning, the number of community care sites was updated in August 2017 from 6,968 to 7,144, across 420 health zones[3]. The MOH estimates that a total of around 21,300 sites will be needed nationwide to meet existing needs. In March 2018, the IMNCI TWG organized a two-day meeting with MCSP support that focused on health information systems enhancements and updating maps for child health. Using their own maps, participants from the invited health zones used national criteria to identify villages eligible for community care sites that did not yet have one. This mapping exercise informed the MOH's plan for establishing new community care sites and also helped in determining their probable locations. In January 2019, MCSP completed an updating of the maps and validated them in the field with the two DPS of Tshopo and Bas-Uélé and the National Program for the Elimination of Cholera and other Diarrheal Diseases.

[3] *Plan Stratégique National de la Santé Communautaire en RDC (2018-2022). Section 2.2.4. Prise en charge des cas dans les Sites de Soins Communautaires*

MCSP established 119 Community Care Sites with the full package (30 in Bas-Uélé and 89 in Tshopo)

USAID/ASF-PSI/MCSP	119
USAID/ASF-PSI/PMI	482
USAID-PROSplus	819
USAID/Malaria Care	239
IRC-WHO/CIDA	1375
SANRU-ASSP/DFID	225
SANRU-Global Fund/UNICEF	1901
SANRU-Global Fund	1666
Save the Children International-ATV	14
Save the Children International-DFID	78
Save the Children International-GSK	50
TOTAL	6968



Partners supporting CCS in the provinces by percent of CCS with the complete package

iCCM/IMNCI module in DHIS2, dashboard, database and website designed. To track the scale up and contributions of iCCM and IMNCI, MCSP worked with an information technology consultant and the IMNCI working group to develop an iCCM/IMNCI web-portal to complement service delivery information in the national HMIS. This module built on a DHIS2 platform, captures data on human resources and training--community health workers (who they are and where they are based); the locations of community care sites, health centers and implementing partners; and routine service data. In addition, MCSP worked with the IMNCI working group to develop a website where all child health data, relevant training materials, policies, guidelines, standards and norms can be stored and easily accessed. The website, which was in the final stages of design when MCSP closed out, will make it possible to track the numbers of trainings conducted, health workers trained, and services delivered by the *Relais Communautaire*. It will also include reports from both NGOs and MOH directorates and divisions and the DPS. Finally, MCSP supported a training of key DSNIS personnel as well as staff from the implementing partners in the management of this system to encourage its completion and use.

National Reproductive Health Policies and Programs (PNSR)

2017- 2020 FP Strategic Plan completed. MCSP, in collaboration with other technical and funding partners, supported the PNSR to draft the National Multisectorial FP Strategic Plan, 2017- 2020, which includes a national communications plan and tools to promote demand for FP services using social and behavioral change and communications (SBCC) approaches. The plan's objectives include the development and distribution of FP teaching materials, SBCC at the community level to increase the demand for FP among men, women, and adolescents, and FP mobilization strategies. MCSP supported Bas-Uélée and Tshopo DPS to develop their own provincial FP plans based on the national strategic plan and supported aspects of its implementation while present in the two provinces.

FP/Postpartum FP (PPFP) reporting systems improved. MCSP provided technical support to the PNSR to revise FP indicators, registers and the DHIS2 interface in an attempt to improve reporting and documentation of PPFP. Further, MCSP in partnership with WHO provided financial and technical support for a workshop to develop guidelines and training modules that integrate PPFP. WHO subsequently used these revised modules for the training of 33 national-level trainers, whose responsibility it was to help the MOH and partners expand services.

MCSP used a number of national trainers to reinforce the provincial PNSR focal points in Tshopo and Bas-Uélé and supported cascade training across eight hospitals, 40 health facilities and 40 community-based distributors. MCSP's FP interventions in Tshopo and Bas-Uélé DPS have convincingly demonstrated that FP/PPFP services are in demand and that the unmet needs in FP in communities where previous service provided were minimal or zero can be quickly addressed with a combination of training, commodity distribution, supervision at both health facility and community-based distributor level, and community outreach.

Division of National Health Information Systems (DSNIS)

Training of National Trainers in District Health Information Systems 2 (DHIS 2) completed. DRC adopted the DHIS2 for its national HMIS and data storage platform in 2014. In addition to working with DSNIS and the IMNCI TWG to develop and test a DHIS2 community module, MCSP also provided technical and financial support in November 2016 for a central-level, six-day DHIS2 training of national trainers. Twenty participants from the D10, D5, PNIRA, PNLMD, PNSR and PNLP participated, with the DSNIS experts serving as their trainers. Following the central-level training, MCSP moved with the national trainers to Tshopo and Bas-Uélé provinces, to train local data managers and health zone management teams on the correct use of DHIS2. This training effort, which was supported by other partners in other parts of the country, improved the quality of available DHIS2 data and increased trainees' understanding of the DHIS2 system and how data should be collected, uploaded, and used to make informed decisions. There is still much work to do to institutionalize data management practices, but MCSP was encouraged to see both the timeliness and completeness of data improving at zonal level in the provinces supported.

National Routine Data Quality Assessment (RDQA) trainers trained. In February 2017, MCSP supported a five-day training for 30 national trainers and facilitators on the use of WHO's RDQA tool and processes. MCSP and the national facilitators then worked with the Tshopo and Bas-Uélé DPS to roll out RDQA training in all eight of the MCSP-supported health zones. Thereafter, MCSP advisors at national and provincial level helped health zone data managers on a monthly basis to track the completeness of their reports and the quality and consistency of the data reported by health facilities. As a result, the MCSP-supported health zones consistently produced higher quality and more reliable data for decision making than other non-MCSP supported health zones. This success inspired the Tshopo and Bas-Uélé DPS and their partners to adopt MCSP's strategy in all of their health zones.

Dashboards introduced and used at health facilities. MCSP helped to introduce a standardized dashboard at health facility level in all of the program-supported health zones. Prominently displayed on the walls of clinics for visitors to see, the dashboards showed monthly the numbers of children under five years of age seeking care, being assessed and treated or assessed and referred for malaria, diarrhea, pneumonia, malnutrition, or severe illness. They also displayed the number of new users of FP. The dashboards tracked the presence of

child health commodities and supported the larger effort to improve data quality and use in local decision-making.

Division of Studies and Planning (DEP)

Lives Saved Tool (LiST) introduced to MOH planners. The effects of implementing different RMNCAH interventions for maternal and child survival has been difficult to measure in the DRC for lack of a suitable methodology. At USAID's request, MCSP's partner John Hopkins University Institute for International Programs trained MOH managers on the use of the LiST tool that has been in use at global and country levels for more than a decade. The LiST tool can be used to estimate the number of lives saved as a result of increasing the coverage of specific intervention or package of interventions. It provides information that is valuable when planning and when advocating for new strategies, activities, and investments. As a result of MCSP's support, terms of reference were drafted for a DEP-led working group leading the integration and use of LiST within the MOH. This group's first activity included using LiST to project the number of lives that could be saved through implementation of the National IMNCI Strategic Plan 2018-2022. The DEP estimates suggest that full implementation of the IMNCI strategic plan strategies and activities could save 314,085 lives of children under five years of age including 41,017 deaths due to malaria, 27,171 due to diarrhea, 21,124 due to pneumonia, 6,581 due to neonatal sepsis and 3,180 related to prematurity. It also showed the potential to reduce the national under five mortality rate from 104 deaths (DHS 2013-2014) to just over 64 per 1000 live births by the year 2022.

Division of Continuing Education (D11)

Primary Health Care (PHC) management training updated and rolled out. Over 80% of health zone management teams had never been trained in primary health care management according to a 2017 MOH review. On behalf of the D11, MCSP updated and revised 16 chapters of norms for PHC management in DRC's 516 health zones. The norms, which were last updated in 2012, now describe in detail how to implement and run the systems required for quality PHC services. In February 2018, after the revised norms were validated by the MOH, Global Fund for TB, Malaria and AIDS funding was allocated to print copies of the 16 updated modules and national trainers trained managers from Kinshasa's thirty health zones. The large USAID-Prosani Plus bilateral project that targets 178 health zones in the country has expressed interest in using the modules to build the management capacity of the zonal health management teams it supports. Better management of health facilities would improve the quality of care they provide and lead to lower rates of maternal and child mortality and improvements in coverage, quality and equity of care.

Directorate of Hygiene (D9)

Clean Clinic Approach (CCA) standards and tools developed and demonstrated in Tshopo and Bas Uélé provinces. MCSP's water sanitation and hygiene (WASH) activities aimed to ensure that health facilities met WASH standards set by the WHO and adapted by the MOH to the DRC context. MCSP worked with the MOH to design an assessment tool for monitoring WASH in health facilities with scoring in four areas: 1) water: access, quantity, and quality; 2) hygiene: hand hygiene, cleaning/disinfection, and sterilization; 3) sanitation: excreta disposal and medical waste management; and 4) health facility management: leadership, accountability, resource management, and community satisfaction. Facilities achieve Clean Clinic Status after scoring an average of 75% over the course of three assessments. Where previous WASH for health facilities approaches and models primarily focused on strengthening infrastructure, MCSP's CCA motivated health providers and facility managers and introduced an accountability system to facilitate and maintain cleanliness and WASH improvements in health care facilities. MCSP worked closely with the national level MOH and DPS to assess and select 35 health facilities in Tshopo and Bas Uélé provinces, develop CCA training modules and tools and train and monitor health facility staff as they operationalized the CCA. Starting with a pilot in 10 health facilities, after demonstrating positive results, MCSP worked with the DPS to expand to an additional 25 health facilities during the last six months of project. The 10-step CCA approach is similar to the "Plan-Do-Study-Act" cycle, which is often used for quality improvement in healthcare settings. CCA empowered facility

staff to identify their needs, develop action plans, and work incrementally towards achieving improved WASH standards. Program activities included facility-to-community outreach that encouraged families to develop good hygiene and sanitation practices at home, as well.

National WASH standards incorporate CCA and lessons learned. DRC's national WASH standards were finalized during workshops held in Kinshasa in 2018, with environmental health experts from various organizations including UNICEF, WHO and the MOH. Based on MCSP's positive results in Tshopo and Bas-Uélé, the MOH standards and WASH for health facilities activities directly reflect MCSP's CCA experience.

Contribution of MCSP "learning" (implementation research) activities

MCSP conducted a number of formal and informal "learning" activities that influenced MOH policy and strategy.

- The *Strengthening Nutrition in the Integrated Community Case Management of Childhood Illness in Democratic Republic of Congo* study in Tshopo and Bas-Uélé provinces addressed a universal problem—inadequate health provider attention to nutrition screening and counseling in the practice of both IMNCI and iCCM. Although the study's purpose was to guide MCSP's own program design, its findings helped strengthen nutrition screening and infant and young child feeding content in the IMNCI and iCCM packages and they were shared through international publications including *Strengthening Nutrition Services within Integrated Community Case Management of Childhood Illnesses in the Democratic Republic of Congo: Evidence to Guide Implementation* in Maternal and Child Nutrition[4] and *Who are the real community health workers in Tshopo Province, Democratic Republic of Congo?,* in BMJ Global Health[5].
- MCSP supported the Child Health Task Force in preparing an *iCCM scale up study* as part of a multi-country exercise to understand the drivers and barriers to the scale up of different evidence-based interventions. DRC first adopted iCCM in 2005 and continues scale up efforts with support from partners. There were over 9,245 community care sites across the country in January 2019, but there is still much to be done to expand and institutionalize this national strategy. The case study documents strengths and weaknesses and encourages the MOH to address them.
- MCSP conducted a systematic analysis of DHIS2 and health facility data to determine whether and how can existing information systems might be used to routinely track the additional and proportional "coverage" of curative health services for children under five after the introduction of iCCM. MCSP's analysis for Tshopo and Bas-Uélé provinces, showed that utilization of child health services increased at both community and facility levels after the introduction of iCCM. A technical brief on tracking quality and use of services before and after introduction of a complete iCCM package is being finalized to explain the methodology used.
- Where previous WASH for health care facility approaches and models primarily focused on strengthening infrastructure, MCSP's CCA institutionalized accountability and motivated health care facility staff to strengthen systems to facilitate and maintain cleanliness and WASH improvements. In the DRC, MCSP's pilot program was implemented according to 10 defined steps[6] starting by an initial evaluation and concluding with rewarding progress and refining priorities and action plans for continued improvements. When the "*Clean Clinic" pilot* in Tshopo and Bas Uélé provinces produced good results on a small scale, the approach was expanded to additional clinics in the two provinces and the experience influenced a new national approach that is being promoted by the Directorate of Hygiene (D9), with UNICEF and WHO support countrywide. Outside of DRC, the CCA has been implemented in five countries since 2015, with consistent success.

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[4] Kavle JA, Pacqué M, Dalglish S, et al. Strengthening nutrition services within integrated community case management (iCCM) of childhood illnesses in the Democratic Republic of Congo: Evidence to guide implementation. Matern Child Nutr. 2019;15(S1):e12725.

[5] Article accepted by BMJ Global Health for publication.

[6] MCSP Case Study: The "Clean Clinic Approach" for WASH in the Democratic Republic of Congo April 2019

Conclusions and Next Steps

MCSP played a unique role in building the technical, operational, and programmatic capacity of the MOH, while simultaneously working with the DPS in Tshopo and Bas-Uélé provinces to introduce an integrated package of iCCM, FP, nutrition and WASH interventions. Despite the MOH's restructuring in 2017 MCSP's support was instrumental in building the organizational capacity of the D10 and reviving the RMNCAH Task Force; strengthening the child health and other national technical working groups; and helping multiple divisions and programs play more effective policy, planning, resource-mobilization, capacity-building, coordination and oversight roles. MCSP not only contributed to the development or revision of important national strategic plans for child health, newborn health, community health and FP, but also helped with their roll out. We did this by introducing and ground-truthing proposed approaches and tools before they were launched, supporting national and provincial capacity building efforts, and contributing to the development of annual operating plans by the D10, its programs and the DPS.

MCSP implemented activities in partnership with the MOH and its working groups and encouraged government leadership at all levels. A great deal was accomplished, but the national MOH directorates, divisions and programs and the Tshopo and Bas-Uélé DPS will continue to need financial and technical support if they are to consolidate project gains and maintain the momentum generated during MCSP's three short years of implementation. MCSP encourages USAID to continue providing the type of need-based technical assistance to the MOH that MCSP and its predecessor projects have provided. It is important for future projects working at the national level to have a "foot on the ground", as MCSP has had, so that their technical guidance is reality based. MCSP also recommends that future technical assistance include robust government-led learning and knowledge management functions. Adopting USAID's collaborating, learning and adapting principles and making knowledge sharing an explicit function of all technical assistance providers would be a valuable Mission strategy. To support this aim, implementation research should continue answering questions that have emerged based on the project's work including how can the MOH ensure that its updated policies, strategies and guidelines are available over time and used by health staff at all levels of the public health system?; what are the actual costs and the added value of integrated community health services?; and others.

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