Understanding *the* 2030 Vision:

Rapid Desk Review of Strategic Documents for Child Health in the Democratic Republic of Congo (DRC)

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CHILD HEALTH TASK FORCE

JSI

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Acronyms

ASRH	Adolescent, Sexual, and Reproductive Health
DHS	Demographic and Health Survey
DPS	Provincial Health Division *Division provincial de la santé*
DRC	Democratic Republic of Congo
EPP	Permanent Provincial Supervisors *Encadreurs provinciaux permanents*
GFF	Global Financing Facility
HGR	General Referral hospital *Hôpital général de référence*
iCCM	Integrated Community Case Management
IMCI	Integrated Management of Childhood Illness
MOH	Ministry of Health
PNCHOLMD	National Program for the Control of Cholera and Diarrheal Diseases *Programme national de lutte contre le choléra et les maladies diarrhéiques*
PNDS	National Health Development Plan *Plan national de développement sanitaire*
PNIRA	National Program for the Control of Acute Respiratory Infections *Programme national de lutte contre les infections respiratoires aiguës*
PNSR	National Program on Reproductive Health *Programme national de la santé de la reproduction*
RMNCAH	Reproductive, Maternal, Neonatal, Child, and Adolescent Health
RTA	Resident Technical Assistant
SDG	Sustainable Development Goals
NMR	Neonatal Mortality Rate *Taux de mortalité néonatale*

Note: List includes some French acronyms in cases where there is no widely accepted English translated version, especially for DRC-specific medical and administrative terms

Executive Summary

As the Democratic Republic of the Congo (DRC) strives to achieve the 2030 vision[1], eliminating deaths due to preventable causes and improving the wellbeing of mothers, newborns, children, and adolescents, the country is focusing on high-impact interventions that target the leading causes of death among children under five years. With the Sustainable Development Goals (SDGs) expanding the focus from child survival to incorporate the concepts of "thrive" and "transform," the Ministry of Health (MOH) and its partners will require targeted, better-coordinated technical assistance to accomplish its vision.

To gain an understanding of national priorities and targets for child health, the global Child Health Task Force[2] conducted a rapid desk review to synthesize strategic documents for child health in the DRC. The review will inform the re-imagining of technical assistance models for child health.

Objectives of the rapid desk review:

1. Understand the DRC's priorities, targets, and implementation strategies to achieve the 2030 Vision.
2. Identify needs in organizational, human, material, and financial resources, as well as their respective gaps.
3. Document gaps in the strategies that can be resolved through improved technical assistance approaches.
4. Recommend short, medium, and long-term actions.

Priorities and targets defined in the DRC's National Health Development Plan (PNDS 2016-2020) to achieve the SDG 3 include:

1. Implement high-impact reproductive, maternal, neonatal, child, and adolescent health (RMNCAH) interventions in 14 of 26 provinces of the country, such as emergency obstetric and neonatal care; integrated management of childhood illnesses (IMCI); skilled attendance at childbirth; antenatal care; immunization plus; family planning; and insecticide-treated mosquito nets.
2. Implement specific interventions for providing sexual and reproductive health services to adolescents.
3. Increase the coverage and delivery of quality nutritional services.
4. Increase access to safe drinking water and use of appropriate sanitation.
5. Finance health services by contracting with financial and technical agencies.
6. Involve communities in the implementation of health services.

[1] The Vision 2030 is the Sustainable Development Goal for child health set by the government of the DRC in line with the Global Strategy for Women's, Children's and Adolescent's Health.
[2] https://www.childhealthtaskforce.org/about

Three strategic mechanisms were identified to achieve the above targets:

1. The development of health zones and continuity of care based on expansion of health facilities that are accessible to all; provision of quality care, and increase community involvement.
2. Support for the development of health zones by allocating sufficient human, material, and financial resources along with efficient management of health information to foster informed decisions in program planning.
3. Governance and management of a multi-sectoral approach.

To achieve targets, the following areas will need to be addressed:

1. **Organizational needs:** Standards, guidelines, and directives for the interventions (RMNCAH; adolescent sexual and reproductive health [ASRH]; nutrition management; water, sanitation, and hygiene [WASH]) and health information system strengthening are required for data collection, data analysis, and validation and/or collaboration with education, agriculture, civil protection, and other sectors.
2. **Human resources:** The perceived needs center on qualification and rational distribution of staff and strengthening of community organizations for implementation of interventions devoted to child health.
3. **Material resources:** The availability of drugs and supplies, particularly the "13 tracer commodities" or 13 essential commodities for RMNCAH and ASRH-specific supplies, materials, and equipment assigned to services at each level of the continuum or health pyramid.
4. **Financial resources:** A substantial budget is required from domestic resources and development partners to address the budget deficit in the public health sector and achieve a gradual reduction of the burden on households to finance healthcare services.

Any future technical assistance approaches will need to resolve issues related to:

- **Organizational capacity gaps**: low national coverage of interventions, low integration and coordination of health services at the operational level, weak management of service delivery systems, low involvement of the private sector, low accountability towards beneficiaries, low rates of effective referral for clinical services between the Health Center and the General Referral Hospital (HGR)
- **Deficits in human resources**: under qualification of health personal, poor distribution of health workers, formal medical training inappropriate for health needs
- **Shortages of material resources and drugs**: low availability of required emergency material and drugs
- **Low functionality, quality, and use of health services**
- **Insufficient financing** of the health system.

Recommendations for the short, medium, and long-term are proposed at the end of the report.

Background: Child Health in the DRC

As the DRC strives to achieve the 2030 vision[3] for children, eliminating deaths due to preventable causes and improving the wellbeing of mothers, newborns, children, and adolescents, it is focusing on high-impact interventions that target the leading causes of death among children under five years. With the Sustainable Development Goals (SDGs) expanding the focus from child survival to incorporate the concepts "thrive" and "transform," the Ministry of Health (MOH) and its partners will require targeted, better coordinated technical assistance to accomplish its vision.

To gain an understanding of national priorities and targets for child health, the Child Health Task Force conducted a rapid desk review to synthesize strategic documents for child health in the DRC. The review's objectives were to:

1. Understand the DRC's priorities, targets, and implementation strategies to achieve the 2030 Vision.
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3. Document gaps in the strategies that can be resolved through improved technical assistance approaches.
4. Recommend short, medium, and long-term actions.

Levels of the DRC Health System

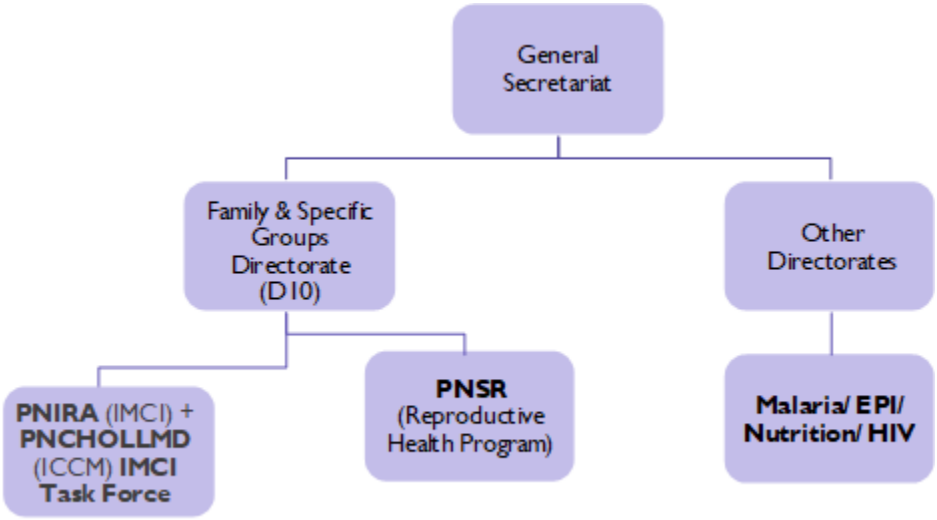
The public health sector in the DRC is organized into three levels: central, intermediate or provincial, and peripheral or operational. The central level (Figure 1) has a normative and regulatory responsibility. It defines policies, strategies, standards, and guidelines and provides advisory support, compliance control, and monitoring of implementation in provinces. This level consists of the General Secretariat and Directorates (departments), including the Family and Specific Group Department, which is responsible for the RMNCAH Task Force and the National Control Programs.

The intermediate level has 26 provincial Divisions of Health (DPS). The DPS level plays a technical role by providing supervision and support of Health Zone Staff in the field in addition to translating strategies and policies into guidance and tools to facilitate implementation at the operational level.

The operational level comprises 516 Health Zones (ZS) with 393 general referral hospitals (HGR) and 8,504 health center catchment areas planned, of which 8,266 have a health center. This level implements the primary health care strategy, which includes child health.

[3] The Vision 2030 is the Sustainable Development Goal for child health set by the government of the DRC in line with the Global Strategy for Women's, Children's and Adolescent's Health.

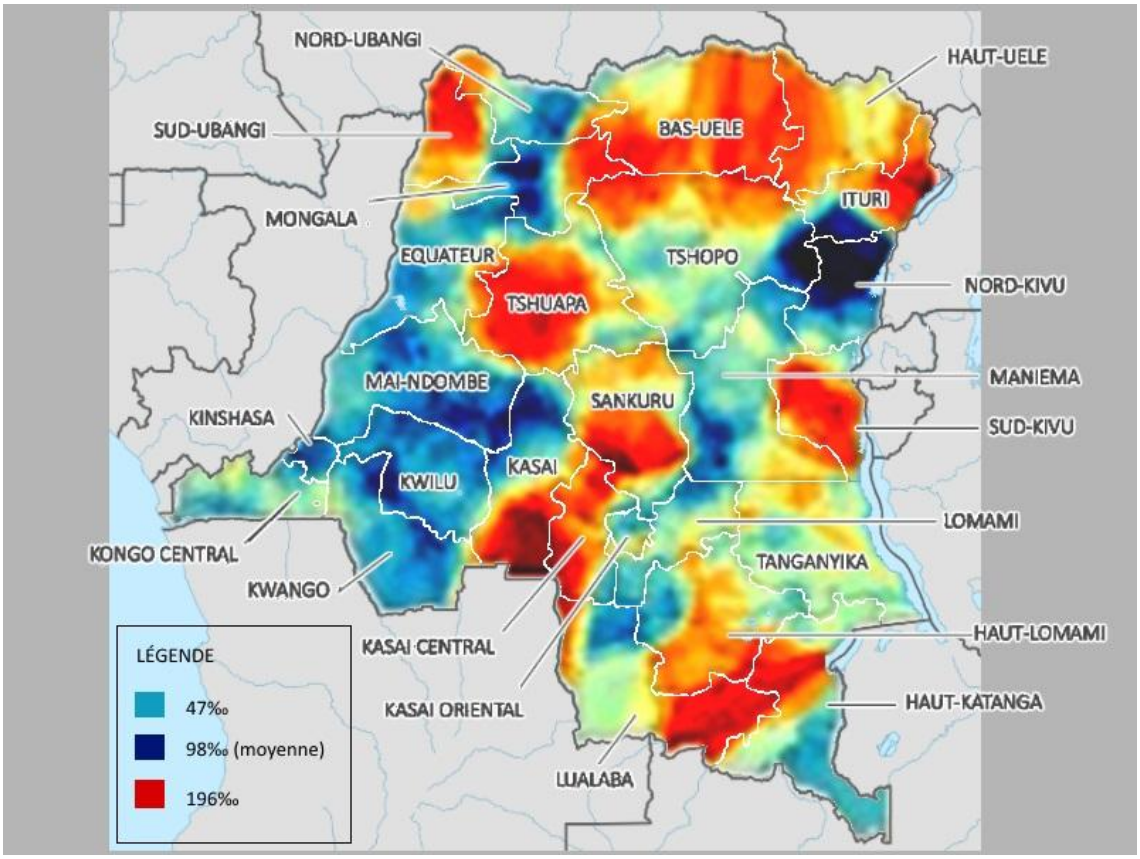
Figure 1: Organization of Child Health at the Central Level of the MOH



Child Health in DRC

For more than 20 years, the DRC has reported high rates of death among children under five years of age. Although the rate declined from 213 per 1,000 live births in 1998 to 104 per 1,000 live births in 2014, child health remains a significant concern for all stakeholders in the country. In some provinces (Sud Ubangi, Bas-Uélé, Haut-Uéle, Ituri, Tshopo, Tshuapa, Sankuru, Sud-Kivu, Kasai Central, KasaÏ, Haut-Katanga and Lualaba), the mortality rate is increasing and is considerably higher than the national average of 98 per 1,000 live births (Figure 2). Newborns and infants are more vulnerable than other age groups with a mortality of 28 and 58, respectively per 1,000 live births. Mothers who die during childbirth are also a group of concern (864 per 100,000 live births), particularly among very young pregnant women, which raises the issue of sexual and reproductive health of adolescents.

Figure 2: Under-5 Mortality Rate in DRC



Legend: Number in the box (x%) represents the under-five deaths/1000 live births in provinces. Source: UNICEF-Data, 2015

Child death is attributed to generally preventable causes: malaria, pneumonia, and diarrhea. Newborns are at risk from prematurity, asphyxia, and neonatal septic infection. Child and newborn death is worsening with contributing external factors, such as increasing poverty, insecurity due to war, and limited access to quality health services. In addition, the DRC has experienced a variety of epidemics, including measles, poliomyelitis, cholera, malaria, yellow fever, and Ebola.

IMCI Strategy

The DRC adopted the IMCI strategy in 1999 to improve case management; however, its scale-up has been limited with national coverage reaching only 49%.[4] Further, only 27% of health personnel used the strategy to manage sick children guidelines and standards are available in 38% of health centers; and only 26% of HGRs in the country adopted its implementation.[5] A component of the IMCI strategy also involved community care workers (ICCM) delivering initial healthcare in communities with limited geographical access to health centers. As a result, 10,179,561 individuals out of 35,855,153 were covered and benefitted from these services.[6] The strategy also addressed malaria, pneumonia, diarrhea, nutritional problems, and other child health problems.

[4] DRC IMNCI National Strategic Plan 2018-2022
[5] DRC Service Assessment and Readiness Assessment Report 2014
[6] Ministère de la Santé. Monitoring Amélioré pour action. 2016

Yet key indicators of these diseases demonstrate the importance of further defining the DRC's strategy on childhood illnesses:

- The prevalence of suspected malaria-related fever is 27%.[7]
- The prevalence of diarrhea is 39%.[8]
- The prevalence of acute respiratory infections is 40%.[9]
- A low coverage of complete immunization (46%).[10]
- A 43% prevalence for stunting and an 8%prevalence for severe malnutrition or low weight for height.[11]
- 22% of newborns who tested positive for HIV were put on antiretroviral drugs (ARVs).[12]
- 39% newborn have been dried thoroughly and kept warm (thermal protection) at birth.[13]

Data from the 25 provinces and Kinshasa are summarized in Table 1.

[7] Demographic and Health Survey in the Democratic Republic of Congo 2013-2014. Rockville, Maryland, USA: MPSMRM, MSP and ICF International (DHS 2013-2014)
[8] Ibid
[9] Ibid
[10] Ibid
[11] Ibid
[12] PNLS Report 2015
[13] Demographic and Health Survey in the Democratic Republic of Congo 2013-2014. Rockville, Maryland, USA: MPSMRM, MSP and ICF International (DHS 2013-2014)

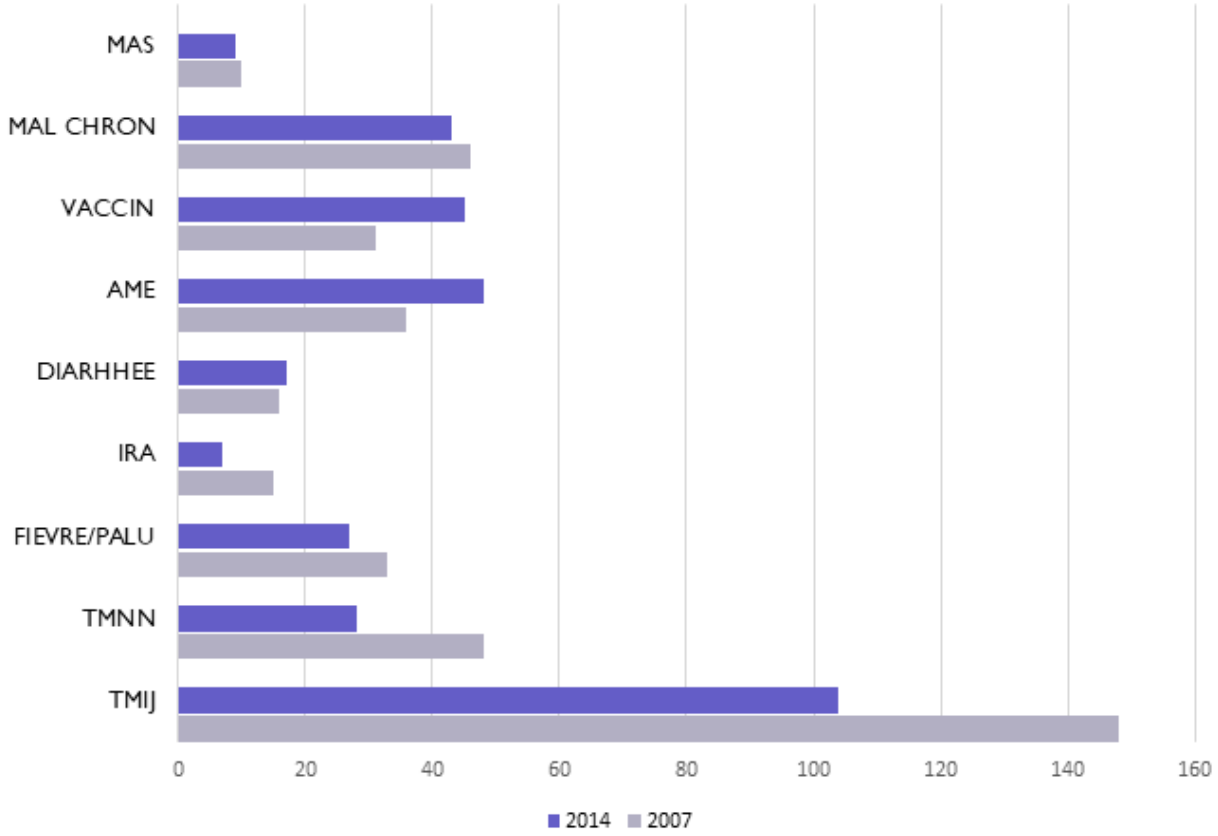
Table 1: Child Health Indicators in DRC Provinces (DHS 2013-2014)

Provinces	TMIJ	TMNN/ 1000 LB	PALU/TDR %	IRA %	DIARRHEA %	MAL CHRON %	MAS %	VACCIN %
Tanganyika	106	28	66	2.3	15.7	51	10.6	13.8
Haut-Lomami	125	35	43.8	6.8	25.4	49.5	9.9	44.9
Sankuru	122	30	31.5	4.5	19.2	50.1	9.6	8.3
Maniema	105	32	44.1	4.3	9.2	46.4	22.7	42
Lomami	122	30	66.2	14.2	20.5	51.1	6.5	36.9
Tshuapa	134	28	26.6	8.8	17.6	47.8	9.2	21.2
Kongo Central	124	46	47.1	2.3	12.4	45.9	11.1	54.7
Sud Kivu	139	47	12	8.2	21.9	53	7.2	62.3
Kasai	135	23	40.3	3.6	24.7	57.9	8.6	32.8
Kasai Central	135	23	47.1	5.9	23.6	46.8	6.1	49.9
Lualaba	127	35	42.5	5.5	21.2	42.1	9.6	31.7
Mongala	130	28	25.3	5.2	12.0	40.9	5.5	5.8
Sud Ubangi	132	28	23.6	12.7	17.6	40.8	6.3	41.9
Kwango	89	26	19.3	6.1	14.5	45.6	11.6	49.2
Ituri	114	32	44.1	1.6	9.6	44.5	7.6	47.4
Nord Ubangi	132	28	47.5	7.1	18.0	41.5	4.4	35.4
Haut-Katanga	126	35	23.3	4.9	16.6	40.4	5.9	51.5
Bas-Uélé	108	28	73.1	7.1	20.7	43.1	6.1	16.6
Haut-Uélé	114	32	66.5	5.0	21.6	40.7	7.6	21.5
Tshopo	114	32	25.9	4.6	5.3	42.4	6.3	26.1
Nord Kivu	65	25	2.9	12.3	13.7	52	4.7	70.6
Equateur	132	28	26.4	11.3	14.3	23.1	4.5	50.1
Kasai oriental	122	30	37.2	4.5	19.4	37.8	6.1	47.7
Mai-Ndombe	89	26	31.1	3.4	12.0	32	14	54.7
Kwilu	89	26	14.4	7.2	13.4	38.9	6.1	38.2
Kinshasa	83	16	17.1	2.5	18.8	17.3	3.5	67.7
NATIONAL	**104**	**28**	**29.5**	**6.7**	**16.8**	**42.7**	**7.9**	**46.3**

TMNN: neonatal mortality rate, **PALU/TDR:** malaria, IRA: pneumonia, **MAL CHRON:** stunting, **MAS:** severe acute malnutrition, **VACCIN:** immunization coverage. These percentages represent the prevalence of respective condition during the survey

Though the country has made progress as shown in Figure 3, the DRC still lags behind the overall sub-Saharan Africa Region in child health indicators. Progress is significantly influenced by standard of living, rural or urban residence, and quality of care received.[14]

Figure 3: Progress in National Child Health Indicators[15]



TMIJ: under-five deaths/1000 live births, TMNN; neonatal deaths/ 1000 live births. **IRA:** pneumonia/%, **AME:** exclusive breastfeeding/% **mas:** severe acute malnutrition/%, **MAL CHRON:** stunting/ %, **Fever/PALU:** malaria/%, **VACCIN:** immunization coverage/%. **These rates per 1000 Live Births and percentages represent the prevalence observed during the survey.**

[14] Demographic and Health Survey in the Democratic Republic of Congo 2013-2014. Rockville, Maryland, USA: MPSMRM, MSP and ICF International

[15] Ministère de la Santé. Monitoring Amélioré pour action. 2016

Rapid Review of Strategic Documents

The DRC has developed several strategic documents for child health that describe child health policies, objectives, strategies, priorities, and targets to achieve. The documents explored in this review included:

- DSCRP-2 (Strategic document for growth and poverty reduction)
- PNDS 2016–2020 (National Health Development Plan)
- PSN (National Strategic Plan for IMCI, Malaria, TB, HIV, Cholera and Diarrhea, Newborn/ENAP, and ASRH)
- DRC Investment Case Framework

Priorities, Strategies, and Targets

The PNDS outlines strategies and benchmark targets for both provinces and health zones. The DRC Investment Case Framework identifies 14 priority provinces where interventions will be implemented: Haut Lomami, Kasaï, Kasaï Central, Kongo Central, Kwango, Lomami, Lualaba, Maniema, Mongala, Sankuru, Sud-Kivu, Sud-Ubangi, Tanganyika, and Tshuapa.

The first PNDS strategy (Strategy I), **development of health zones and continuity of care**, aims to increase access to quality healthcare for all citizens. The country plans to increase health zone coverage from 30% in 2015 to 60% by the end of 2020.[16] The second strategy (Strategy II), **support for the development of health zones**, is meant to increase the allocation of competent health workers to cover at least 50% of health facilities.[17] It also includes support for:

- Rehabilitation or construction of at least 80% of targeted infrastructure;
- Availability, at all system levels, of 13 essential "tracer" products for RMNCAH services (oxytocin, misoprostol, magnesium sulfate, gentamicin, antenatal corticosteroids, chlorhexidine, auto-inflatable balloon and masks, amoxicillin, oral rehydration solution (ORS), zinc, female condoms, contraceptive implants, contraceptive pills) as well as medicine from other specialized programs such as adolescent and reproductive health programs;
- Improvement of accessibility to public health funding by at least 30%;
- Implementation of sufficient protection mechanism for the poorest households from the financial risks of health care costs often in the form of direct cash payments;
- Availability of quality data to enable evidence-based decisions in 80% of health situations; and
- Increased access to safe drinking water and usage of appropriate toilets, and 10% reduction in the prevalence of waterborne diseases by 2020.

Table 2 describes specific goals associated with these two strategies.

[16] PNDS 2019-2022 (National Health Development Plan)
[17] In reality, out of pocket expenditure is higher than reported figures. See footnote 9.

Table 2: Priorities, Strategies, and Targets for DRC Health Development[18]

PRIORITIES	STRATEGIES	TARGETS
Implement high impact interventions of RMNCAH in 14 priority provinces	Strategy I	39% of intervention's coverage by 2021 (baseline 27%, 2015)
Implement specific interventions for ASRH	Strategy I	50% of intervention's coverage in 258 health zones by 2021 (baseline 15.7%, 2015)
Increase access to safe drinking water and use of appropriate toilets	Strategy II	• 70% of targeted population access to safe drinking water (baseline 50.4%, 2014) • 30% of targeted population use toilets (20.5%, 2014) • 10% of waterborne diseases reduction (no baseline)
To manage malnutrition and promote nutrition for children in the community	Strategy I Strategy II	Reduction of stunting to 33% by 2021 (baseline 48%, 2014)
Finance health system by contracting with technical and financial agencies	Strategy I	• Implement social protection mechanisms for the poorest households by reducing payment in cash to 60% (baseline 90%, 2013[DK1]) • Increase public financing to 30% of budget (baseline 13%, 2014)
Ash	Strategy I	50% of communities involved in the development of health zones (baseline 19%, 2015).

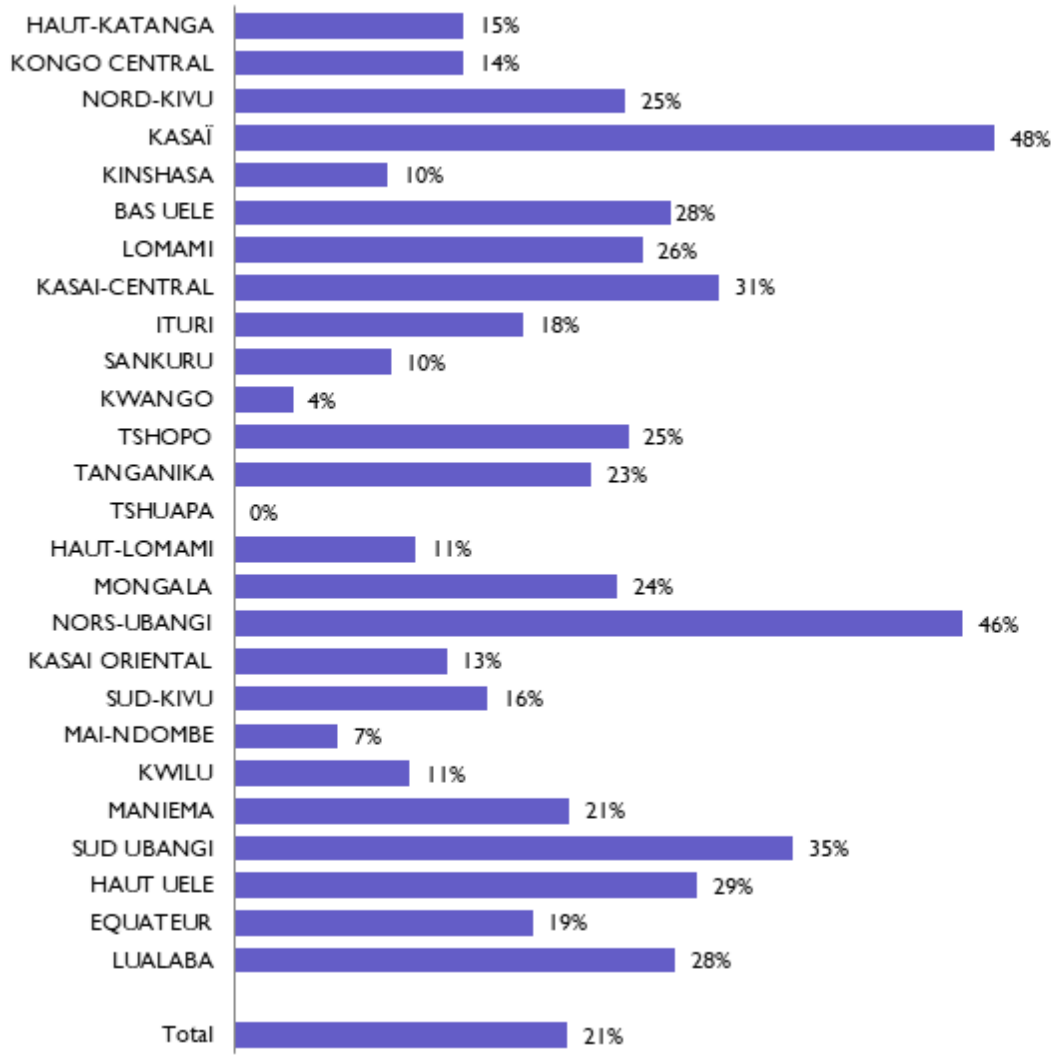
Needs and Gaps

To meet the MOH organizational needs, it will be imperative to clearly define how to operationalize and measure achievements within the overarching strategies. Currently, only 38% of health facilities have guidelines and standards for RMNCAH interventions, and the coverage of these interventions is below 30%.[19] MOH decision-makers work in silos and rarely liaise with colleagues from other ministries, such as education, agriculture, or civil protection and no forum for multi-sectoral discussion or collaboration exists.

The DRC's health workforce has a dearth of qualified personnel and there are many disparities in the distribution of qualified staff across the country. The curriculum for health sciences pre-service training is revised and updated by the Ministry of Higher Education, but its content does not currently reflect communities' needs, especially in child health. As a result, health workers need intensive in-service training, which requires considerable resources in time and money (Figure 4).

[18] PNDS 2016-2020 (National Health Development Plan)
[19] DRC Service Assessment and Readiness Assessment Report 2014

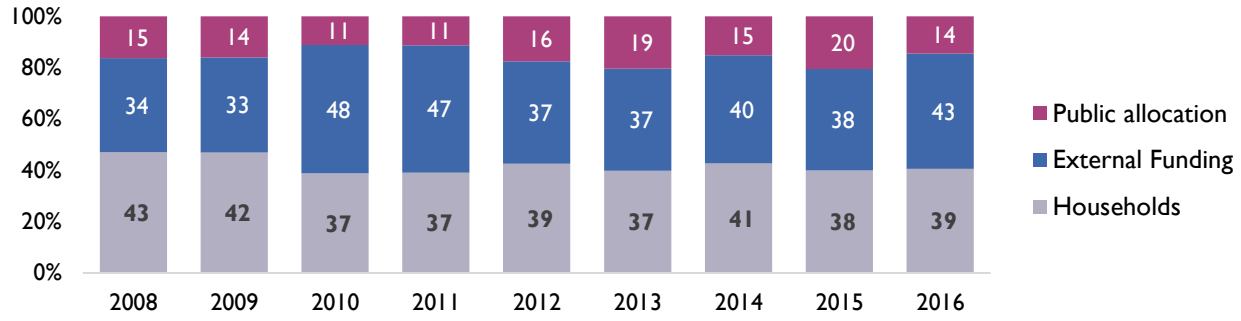
Figure 4: Distribution of Qualified Personnel Trained for IMNCI Services



Source: MAA 2016

Expenditure on health in the DRC was low at $1,213 per capita, annually between 2008 and 2012. Total health expenditures were $876 million in 2009, declining to $830 million in 2010, with a partial recovery to $843 million in 2012. Households were the largest contributors, closely followed by multilateral aid. The country's central government contributes 11% of the total expenditure (Figure 5). The proportion of health in the national budget has ranged between 4% and 5%, far below the commitments made in the 2001 Abuja Declaration. Nevertheless, the budget has largely increased in 2016 to attain 96% of domestic funds in the health sector, which is largely due to increases in both administrative charges within the MOH and social expenditure. The chart below shows how the contributions of each stakeholder have changed in recent years.

Figure 5: Contributions of stakeholders in the total health expenditures in DRC[20]



According to the Financial Global Health Database, which reports how much is spent on health per person, in 2015 the DRC spent a total of $44 per person. Of this total, $18 came from development assistance, $16 from out-of-pocket spending, $7 from the government, and $3 from prepaid private spending. However, in reality, the out-of-pocket spending is higher than $16 as reported by DHS-2014 (around $28 per person).[21]

To implement the National Health Development Plan 2016–2020, the DRC developed an investment case framework in 2016. The first priority is scaling-up the availability of a minimum package of RMNCAH health services in the 14 underserved provinces through a collaborative multi-stakeholder process. This high-impact priority package is budgeted at $1,959,936,247 and funded at $1,200,273,314 (61.2%). Table 3 below details each partner's contribution of the additional financing (note the remaining gap of around 38% of the amount budgeted). Table 4 describes the types of resources needed.

Table 3: Funding Contributions to Scale-Up the RMNCAH Package (DRC Investment)[22]

PARTNER	CONTRIBUTION ($)	%
MOH	$181,167,943	15
Private sector	$132,440,609	11
Households	$94,330,918	7.85
USAID	$107,383,983 + $3,500,000	9.2
UNPFA	$11,025,000	0.9
UNICEF	$74,955,115	6.2
World Bank	$70,377,606 + $120,000,000	15.8
Gavi	$184,482,615	15.4
The Global funds	$180,609,525	15
Global Finance Facility	$40,000,000+	3.3
Total	**$1,036,773,314 + $163,500,000**	**100**

[20] PNDS 2016-2020 (National Health Development Plan)
[21] See footnote 9
[22] DRC Investment framework for RMNCAH interventions, 2017

Table 4: Resources Needed for RMNCAH Interventions

RESOURCES	NEEDS	GAPS
ORGANIZATIONAL	• Standards and guidelines for the priority interventions, • Strengthening the information system • Strengthening intersectoral collaboration with ministries of education, agriculture, civil protection, and others	• 237 Hôpital Général de Référence HGR and 4,998 Centre de santé (CS) to be covered • Analysis of collected data for making decisions • Development of intersectoral coordination (functional Task Force) including staff of other ministries
HUMAN	• Qualification and rational distribution of staff • Strengthening community organizations	• 1,120 Medical Doctors and 2,250 nurses to be trained in RMNCAH and reassigned • 31% of community organizations strengthened
MATERIAL	• Availability of drugs particularly the "13 essential" for RMNCAH- and ASRH-specific supplies, materials, and equipment assigned to services	• 49% (gap) of essential drugs, material and supplies to be procured
FINANCIAL	• Adequate budget for RMNCAH activities • Adequate funding for child health	• Increase of budget allocation to be covered to fund health system • $744,775,774 to be mobilized for child health through RMNCAH by 2020

Reimagining Technical Assistance

To implement the DRC's vision for improved child health, it will be necessary to clearly define the role of technical assistance during this project. Technical assistance can be seen as a framework for health systems strengthening programs, especially in limited-resource settings, such as the DRC, by means of knowledge transfer and capacity building. Unfortunately, it is often evaluated on the basis of the expected and measurable results and not on the behavioral change that it generates. It is understood by local teams as a strengthening of their capabilities to play their full role in the field, and includes technical, material, and financial support. This understanding must be harmonized with all stakeholders.

Donors commonly fund projects and seek rapid results and data to document them. This mindset leads to multiple donor coordination mechanisms, duplication of interventions, and waste of resources despite multiple technical assistance activities. Moreover, the end of a grant or project often leads to the loss of the technical value added during implementation and results in regression back to the initial capacity issues.

Health zones, or districts, are intended to be led by polyvalent district management teams of about five or six individuals who are responsible for the development of the health zone. Yet, the multiplication of externally funded disease control programs with their specific operational mechanisms results in an increased number of personnel, each representing a specific program with its own operational, financial, and material resources. This fragmentation disturbs the coordination mechanisms of the interventions, both at the operational and provincial level.

The DRC's government formulated a comprehensive health system strengthening strategy (HSSS) in 2005. Since 2006, a study as a pilot project was conducted in North Kivu and Kasaï Oriental provinces to adapt the

structure and functions of the provincial health divisions to support districts rather than acting primarily as a relay for technical programs of the MOH. The provincial level remains an obstacle to health system reform. It was often considered as intermediary for decisions, standards, and guidelines created at the Central Level. The reform, however, aimed to remedy this by empowering the province to become a decision center and support of health zones. Some provinces were chosen to carry out this pilot reform as early as 2006. This experience has been improved upon, replicated, and scaled-up to other provinces[23] and led to the reform of the health system, aiming at a rationalization of the resources and a strengthening of the provincial level to supervise and follow-up the implementation of interventions. The results were adopted as strategies into the PNDS 2016-2020.

New initiatives to improve technical assistance should build on existing approaches and learn from local experts on what does and does not work.

[23] WHO_HIS_HGF_Case study/DRC-Improving aid coordination in the health sector. 2015.

Recommendations

Short-Term

At the central level:

- Strengthen community health organizations by improving the managerial capabilities of their members.
- Define a framework for accountability with communities.
- Involve stakeholders in allocation of sufficient budget for activities.
- Increase the involvement of the private sector.
- Redefine technical assistance.
- Facilitate procurement of drugs, materials, and supplies.

At the provincial level:

- Improve coordination of interventions in the field.
- Improve the functionality of services and the quality of interventions.
- Strengthen the technical provincial team to supervise and follow up the implementation of interventions.

At the operational level:

- Strengthen community involvement in situation analysis and elaboration of different plans.

Mid- to Long-Term

- Scale-up coverage of the minimum package of interventions in the remaining health facilities (MOH and its partners).
- Improve formal medical training for at least 50% of personnel (MOH and its partners).
- Facilitate retention of competent personnel (all levels).

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