Democratic Republic of the Congo

Ministry of Health

Secretary General

FINAL REPORT

The process of re-imagining technical support for maternal, newborn, child health and health systems strengthening in the DRC

Kinshasa, March 2020

TABLE OF CONTENTS

ABBREVIATIONS AND ACRONYMS

CCT	Technical coordination committee
CDMT	Medium term expenditure framework
CDR	Regional distribution center
CNP-SS	National Steering Committee for the Health Sector
CPN	Prenatal consultation
CRVS	Civil registration and vital statistics
DRC	Democratic Republic of the Congo
DPS	Provincial Division of Health
FEDECAME	Federation of central supplies and medicines
FP	Family planning
GIBS	Inter-donor health group
HCD	Human centered design
HSS	Health systems strengthening
iCCM	Integrated community case management
IGS	Inspectorate for Health
IPS	Provincial Health Inspectorate
JSI	John Snow Inc./Research & Training Institute, Inc.
M&E	Monitoring & evaluation
MOH	Ministry of Health
NHIS	National health information system
PCIMA	Integrated case management of malnutrition
PDSS	Health System Development Project
PNDS	National Health Development Plan
PNSD	National Strategic Development Plan
PNIRA	National Program to Fight Acute Respiratory Infections
RMNCAH+N	Reproductive, Maternal, Newborn, Child, and Adolescent Health, and Nutrition
SDG	Sustainable Development Goals
SG	Secretary General
SNAME	National medicine supply chain system
TOR	Terms of reference
UHC	Universal health coverage

ACKNOWLEDGMENTS

This report is the result of deep reflection and effort of national and international experts who have agreed to offer their expertise in order to provide the Ministry of Health (MOH) with a quality tool, the implementation of which will help improve technical support for Reproductive, Maternal, Newborn, Child, and Adolescent Health, and Nutrition (RMNCAH+N) and the health system in the Democratic Republic of Congo (DRC).

Thus, we extend our sincere thanks to the Secretary General for Health for his personal commitment, his direction and the appointment of our humble person to lead the process that led to this important document.

Our thanks also go to all the experts from the MOH, civil society and technical and financial partners who formed the country co-creation team for all their reflections and contributions, the richness of which is reflected in the quality of the work we present in this document.

Special thanks to the Child Health Task Force, JSI Research & Training Institute, Inc. (JSI), Sonder Collective, and the Bill & Melinda Gates Foundation for the very special technical support and funding, without which this process would not have been successful.

May all those who, from far and near, have contributed to this process find here the expression of our gratitude.

Dr Jean Fidèle ILUNGA MUBAYI

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EXECUTIVE SUMMARY

By endorsing the Sustainable Development Goals (SDGs), the DRC has made a commitment to strengthen its fragile health system to allow the provision of quality and accessible services, particularly those for women, newborns, children and adolescents, as well as the improvement of their nutritional status in order to obtain a significant and lasting reduction of reported death rates in recent decades. One way to do this is to get an update from all stakeholders on the technical support they provide to the country. It is in this context that it is necessary to take note of the project "Re-imagining technical support in the DRC" led by JSI and Sonder Collective, with funding from the Bill and Melinda Gates Foundation to support the MOH.

Through a literature review and a human-centered design (HCD) approach using personalized interviews targeting all stakeholders and workshops on co-creating ideas and concepts, an analysis of the situation has been obtained and possible solutions have been proposed. This process aimed to obtain a roadmap for implementing the areas of change identified in a collaborative manner by the Government, donors, technical and financial partners, civil society and the community.

From the analysis of the situation, two essential facts concerning technical support were noted: (i) health financing is essentially dependent on direct payments from the population and external aid due to weak contributions from the Government; (ii) weak regulation of the sector due to less active leadership which leads on the one hand, to the creation of projects by donors in search of quick results and data to document them and, on the other hand, to frustration and loss of professional identity among health workers.

These findings were revealed by disproportionate management costs, wasted resources, fragmentation of services and programs - or even duplication - organizational and managerial weaknesses, unproductive deployment of human resources and duplication of supply chains for medicine, inputs and health products, resulting in the low use as well as the low quality of care of health services.

Four areas of change have been identified through the HCD method, in particular: (i) optimizing finances and building for the long term, (ii) support to strengthen governance, (iii) cultivating collaboration and transparency between all stakeholders, (iv) reduce dependencies in favor of sustainability.

Service principles to be respected and recommendations have been issued, and conceptual solutions for each area of change have been prioritized. A contractual, monitoring and evaluation and accountability framework for this technical support was developed based on what already exists, namely the National Strategic Plan for Universal Health Coverage 2020-2030, the National Health Development Plan (PNDS) 2019-2022, the Integrated Strategic Plan for Reproductive, Maternal, Newborn, Child and Adolescent, and Nutrition (PSI RMNCAH+N) 2019-2022, the Investment Framework 2017-2021, the Health Financing Strategy and the Single Contract, etc. The guidelines for mapping interventions and funding areas of change by partner have been defined. The roadmap was developed with implementation costs added to it.

INTRODUCTION

1.1 Background and purpose of the initiative

The health of mothers, newborns, children and adolescents, including their nutritional status, is a primary concern and a priority on the agenda of all governments of the world. Thus, the Secretary General of the United Nations launched the global strategy for the promotion of the health of women, newborns, children and adolescents between 2016 and 2030 with a view to accelerate the implementation of the SDGs, for "Every Woman, Every Child".

The DRC, like many countries in the world, has endorsed the SDGs and is working to ensure Universal Health Coverage (UHC) for the vulnerable group of women, children and adolescents.

Despite the number of stakeholders, the importance of the funds mobilized on the part of the Government, international partners, and the contribution of the community in the health sector, the results from projections of indicators based on data from national surveys remain mixed. In addition to this, evaluations of health financing have shown that several health financing mechanisms coexist without a precise political orientation to better channel them towards the priorities of the sector. The reasons for this crisis also include persistent weaknesses in the health system.

Indeed, there are fundamental questions about how to sustainably improve health outcomes and how to provide quality maternal, newborn and child health services more efficiently and more effectively in the DRC. How can *better* technical support *accelerate annual rates of decline* in maternal, newborn, and infant mortality?

With the reduction of international budgets, it is time for the DRC to maximize the effectiveness of the funds available for technical support in order to obtain better health results. To remedy this, it is imperative to reflect on the effectiveness of technical support as a key ingredient for improving planning and delivery of health services due to lack of alignment with the country's priorities, lack of coordination with government and other stakeholders, focus on short-term gains, and the lack of a systems approach to solving the public health problems of this specific group and the health system.

This is how the DRC received technical and financial support from the Bill & Melinda Gates Foundation, as part of the Child Health Task Force project in partnership with JSI and Sonder Collective, to understand what effective technical support looks like for all actors involved in its establishment (donors, suppliers, governments and beneficiaries), the proper functioning of technical support, and find ways to "concretely improve the process of designing and implementing technical support" in the DRC.

At the start of the process, the project focused on child health. In March 2019, the scope of the project went from child health to maternal, newborn and child health as well as nutrition and health systems strengthening. With this change, the project focused on re-imagining aspects of technical support that have an impact on the wider health system, including interactions between key players and the transfer of decision-making power from donors to the country. This is based on the recognition that, although technical services for maternal, newborn and child health remain at the heart of the vision of the 2030 SDGs and technical support projects funded by donors, these services can only be provided if the health system has the capacity (leadership and governance) to manage them and funding to provide key inputs into service delivery.

It is in this context that the DRC MOH is committed to re-imagining a new model of technical support. using the HCD approach so that they can have greater potential to fully play their leadership

role at all levels of the system to guarantee quality and equitable RMNCAH+N services in order to save the lives of women, children and adolescents in a sustainable manner.

In preparing this document, the term "*technical support*" was preferred to "technical assistance." Indeed, "technical assistance" has a connotation of assisting, which is derogatory even if it is a common term. "Technical support" should be the same, but with an attitude of mutual respect and collaboration.

1.2 Aim and objectives

The aim sought in the implementation of technical support is to contribute to reducing the mortality of mothers, newborns, children and adolescents in the DRC.

Thus, the general objective is to get the various stakeholders to create a roadmap for the application of new norms and standards of technical support that can be implemented in a wide range of initiatives in order to improve the quality and efficiency of the services provided for RMNCAH+N in the DRC.

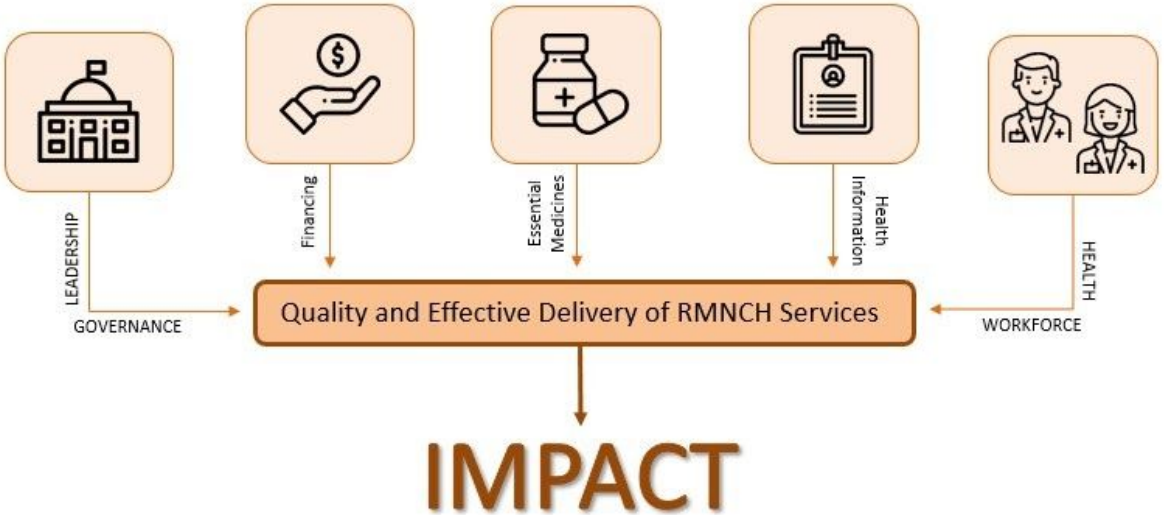


Figure 1: Conceptual model of the impact achieved by reinforcing the health system for quality and effective delivery of RMNCH+N services

Specifically, it was a question of:

- Analyzing, with the key actors of the DRC health system, anthropological knowledge on the various concepts of technical support;
- Analyzing the challenges of technical support in the DRC;
- Identifying the areas of opportunity likely to create a change in the health ecosystem in the DRC;
- Designing the principles and areas of change;
- Creating a roadmap containing conceptual solutions.

1.3 Expected results

At the end of this process, a roadmap for change containing the areas of change, the principles of services to be respected and the main recommendations were drawn up.

New frameworks, models, tools and practices linked to technical support are therefore accepted and adopted by the key players in the health system in the DRC.

METHODOLOGY AND ORGANIZATIONAL FRAMEWORK OF THE PROCESS

2.1. Document review

To contribute to the achievement of SDG3, a quick review and synthesis of country documents and strategies had been conducted at the beginning of the first phase of this process. Its specific objectives were: (i) to identify priorities, targets and implementation strategies based on the 2030 vision, (ii) to identify human, material, financial and organizational resources needs as well as their deficits or gaps to be filled, (iii) determine the gaps in the strategies for achieving this vision which can be resolved by redefining technical support, and finally (iv) propose short, medium and long term actions that can be carried out at different levels.

2.1.1. Priorities, targets, and strategies

At the dawn of 2030, the DRC aims for all women, newborns, children and adolescents to benefit from universal access to quality services and care through an efficient national health system to end preventable deaths (*survive*), ensure good health and well-being (*thrive*) and expand supportive environments (*transform*).

In order to allow better integration of the SDGs, the DRC contextualized and integrated the targets of these objectives in the Country Strategic Plans, among others the 2017-2021 National Strategic Development Plan (PNSD), the 2020-2030 National Strategic Plan on UHC where a focus was placed on high-impact interventions for RMNCH+N in the 2019-2022 PNDS. To strengthen the health system particularly for this vulnerable group and to avoid the verticalization of interventions and thus improve the quality and efficiency of service delivery for RMNCH+N in the DRC, the technical support will draw priorities, targets and strategies of the Investment Framework which is now included in the 2019-2022 PNDS (see Table 1).

This Investment Framework defines 12 priority interventions grouped into three packages making it possible to respond to the main determinants of maternal, neonatal and infant mortality, but also to more systemic bottlenecks. However, related activities may be subject to adaptation according to the roadmap for technical support implementation.

Table 1: Description of the priorities for RMNCH+N in the DRC, Investment Framework 2017-2021

Priorities	Intervention Package	2021 Targets of the Investment Framework (for the 14 targeted provinces)	PNDS Strategies
Implementation of essential RMNCAH+N services as well as services for survivors of SGBV			
Priority 1	Implementation of the essential, quality RMNCAH+N services package, as well as services for survivors of sexual and gender based violence (SGBV). (RMNCAH+N service package, family kits and SGBV services)	* 35% of the population benefits from primary health care services (nutrition, family planning [FP], prenatal consultations [CPN], etc.) * 10% of the population has access to family kits * At least 10% of women who have suffered sexual violence are cared for	Axis 1 & 2 Program 1 & 10
Priority 2	Improve the quality of reproductive health interventions offered for young people and adolescents	* Each health zone has one space for adolescents and young people to get information, for a total of 251 * 30 people at the provincial level and all peer educators and key medical personnel from the 251 facilities are trained and monitored	Axis 1 & 2 Program 1, 3 & 10

	(awareness of youth and adolescent reproductive health services)		
Priority 3	Increase the coverage and quality of nutrition services (Vitamin A campaign and deworming in Mébendazole, integrated case management of malnutrition [PCIMA], establishment of canteens in schools and food production)	* All children under the age of five benefit from Vitamin A supplementation and deworming, as do pregnant women * All severely malnourished children under five are cared for * A canteen is available in each of the five provinces most affected in terms of malnutrition * Increase in the availability of fortified and healthy foods in markets	Axis 1 & 2 Program 1, 10 and 11
Priority 4	Accelerate access to clean water and the use of improved toilets (establishment of 2000 clean villages)	* 55% of the population has access to a clean water source * 25% use improved latrines (the reduction rate of water-borne diseases is 10% in the 14 provinces)	Axis 1 & 2 Program 1, 6 and 10
Methods of implementing the essential RMNCAH+N services			
Priority 5	Contracting between purchasing agencies and health facilities for the supply needed for the package of RMNCAH+N services	* Establishment of a EUP in each province	Axes 1, 2 and 3 Program 1, 3, 6, 10 and 21
Priority 6	Implementation of the quality package of RMNCAH+N services via the community approach	* Two meetings per year on community volunteers and health committees in all health zones * At least one message on key themes is broadcast on community radio by community volunteers * Twice a year, schools organize days devoted to youth and adolescent reproductive health problems and once a month there is an awareness raising day * Three surveys to be conducted on the evaluation of the quality of health services and patient satisfaction * At least 50% of the health zones of the 14 DPS have set up iCCM	Axes 1, 2 and 3 Program 1, 2, 6, 10
Strengthening the health system to support the implementation of essential RMNCAH+N services			
Priority 7	Improve the supply of drugs and supply chains (Strengthen storage capacities and distribution of national medicine supply chain system [SNAME] and procurement system of the federation of central supplies and medicines [FEDECAME])	* 7 existing regional distribution centers (CDRs) are rehabilitated * 7 new CDRs are built * Working capital is available * A FEDECAME business plan is developed * Availability of 80% of tracer drugs in general reference hospitals and health centers	Axis 2, Program 11, 12, 15 and 20

Priority 8	Strengthen the distribution and quality of human resources	* 20% of salaried staff retires * 100% of medical staff are trained in RMNCAH+N * A quality control system is implemented * Training institutions are subject to annual inspections * The number of midwifery graduates increases by 25%	Axis 2, Program 8, 9 and 10
Priority 9	Improve the budget gap, efficiency and financial access for the poor to high-impact RMNCAH+N services	* Some reforms are initiated to improve administration and revenue collection (use of the medium term expenditure framework [CDMT]) * Implementation of the single contract in the provinces * 30% reduction in direct payment to households (State subsidy and strategic purchase for the poorest and most destitute in RMNCAH+N services)	Axes 2 and 3 Program 21 and 24
Priority 10	Strengthening governance	* All resolutions of the National Steering Committee for the Health Sector (CNP-SS) are implemented * The directives relating to RMNCAH+N are disseminated * Implementation of import control mechanisms	Axis 3, Program 23 and 25
Priority 11	Strengthen the national health information system (NHIS) and information systems on drugs and human resources, and monitor the quality of RMNCAH+N interventions	* DHIS2 is operational in the 14 provinces and is accompanied by a DHIS2 portal * An IGL system is operational in 14 provinces * An IHRIS system is operational at the national level * A computerized database is in place to facilitate the encoding of civil status data / DHIS2 * Support for annual monitoring of RMNCAH+N interventions * Support for PNDS review missions, which follow the same indicators as the PNDS	Axis 2, Program 17, 18 and 19
Priority 12	Creation of a functional civil status registry	* 780 civil status offices are created or rehabilitated (out of 15 provinces) * The information system staff of the civil status offices are trained * 600,000 delayed birth certificates (as part of catch-up campaigns in schools) are produced in the 15 provinces in 5 years; 200,000 delayed death certificates (as part of catch-up campaigns) are produced * A national civil status program (civil registration and vital statistics [CRVS]) is available	Axes 1 and 2 Program 1, 3, 10 and 15

2.1.2 Needs and gaps in human, material, financial, and organizational resources

The different problems identified as gaps to be filled are grouped in Table 2.

Table 2: Distribution of RMNCAH+N programmatic needs and gaps to be filled according to resources in DRC, 2017 *(Source: technical support document review, JSI, August 2018)*

Resources	Needs	Gaps to be filled
Organizational	* Standards and guidelines for interventions, * Reinforcement of the information system and monitoring * Reinforcement of intersectoral collaboration with other ministries (education, agriculture, interior, etc.)	* 237 general reference hospitals and 4998 health centers to be covered * Analysis of data collected for decision-making * Development of intersectoral coordination (Functional Task Force) including other ministries

Human	* Qualification and their rational distribution * Revitalization of community-based organizations	* 1,120 doctors and 2,250 nurses to train and reassign * 31% of community-based organizations revitalized
Material	* Availability of 13 tracers for RMNCAH+N and specific materials and inputs for youth and adolescent reproductive health services	* 49% of drugs, inputs and materials to be allocated
Financial	* Substantial budget * Substantial financing of RMNCAH+N	* Health budget increased * US $744,775,774 to be mobilized for child health through RMNCAH+N by 2020

2.1.3 Strategic gaps to achieving the 2030 vision to be improved by technical support

Starting in 2005 with the adoption of the strategy for strengthening health systems, the process of revitalizing the health sector in the DRC had provided a framework for reforms aimed at overcoming the inefficiencies of the sector and the marginalization of national policy development in the context of dependence on external aid.

At the root of the root causes of this dysfunction are the collapse of the State and the economy. As for the health sector, two other elements worsened this grim picture:

(i) Public funding from the Government withered away from 1990, making health funding almost entirely dependent on direct payments and external aid.
(ii) Without public funding and weak national leadership, regulation of the health sector has evaporated[1].

This situation has had serious consequences in the health system for both partners (donors) and users (health workers), namely:

* The creation of projects by donors in search of rapid results and data to document them, leading to multiple donor coordination mechanisms and project management units, and most importantly, duplication and waste of resources.
* The frustration and erosion of professional identity among health workers who found themselves with little time to provide real health care. Logistics has fragmented and the multiplication of supply chains has led to stock-outs in some health centers and hospitals, and an excess of supplies in others.

Humanitarian assistance and official development assistance have become one of the few economic sectors in operation and, with few job opportunities, the health worker profession has become relatively attractive. Unsurprisingly, the quality of services quickly deteriorated with alarming health indicators, while the institutional memory of a country that had been a pioneer in the development of the health district model in Africa began to disappear.

These inefficiencies have taken different forms: disproportionate management costs; waste, duplication and ineffectiveness due to the fragmentation of services and programs; organizational and managerial inefficiencies; unproductive deployment of labor; and duplication of supply chains for medicines and health products.

To remedy this, the DRC has experimented in-depth with the reform of the DPS with the view of eliminating the office structure of the DPS in favor of a managerial team dedicated to technical

[1] Kalambay H et Van Lerberghe W, Improving health system efficiency, DRC Improving aid coordination in the health sector, World Health Organization 2015

support in the health zone. Two approaches taken by the technical support have proved to be essential: one being a "resident technical assistant" coming to support both central and provincial administration and the other that of "permanent provincial supervisors" dedicated to capacity building of ECZS.

The resident technical assistant is external to the local hierarchy, while the permanent provincial supervisors are part of it and provide leadership. Resident technical assistants, in addition to interpersonal skills, must have managerial skills such as that of a project manager, and scientists to bring about change. While the permanent provincial supervisors must be proven field technicians who know the local particularities and have a sense of critical perspective and versatility.

Table 3 below describes the functions of the technical assistants.

Table 3: Description of the technical functions of the resident technical assistant and the permanent provincial supervisors by strategic axes of the PNDS, DRC

Strategic axes of the PNDS 2019-2022	Function of technical support	
	Resident Technical Assistant	**Permanent Provincial Supervisor**
Development of health zones and continuity of care	* Quality improvement of the service packages offered to the population * Improvement of the services provided at the secondary and tertiary referral facilities	* Rationalization of the functioning of care structures * Strengthening of community dynamics * Promotion of health services * Extension of community care sites in health area not covered and in accordance with the coverage plans of the health zones
Support for health zone development	* Improvement of basic training * Health staff skills development * Mobilization, pooling and rationalization of resource allocation * Development of risk sharing and health financing mechanisms	* Improving the availability and retention of competent human resources in health * Control of the needs, management, and supply of drugs, vaccines, contraceptives and specific quality inputs in health facilities * Improved financial resource management in health facilities
Governance and management of the sector	* Institutional capacity building of the MOH * Strengthening health sector coordination * Strengthening inter-sectoral collaboration	* Strengthening the mechanisms for monitoring the application of sector standards and directives

2.1.4 Recommendations for all stakeholders

In the short term

- Improve the coordination, quality and accessibility of interventions in the field
- Improve the organization of services as well as their quality
- Increase the involvement of the private sector
- Define an accountability framework
- Realign the various stakeholders on the priorities for sufficient funding
- Increase the functionality of services
- Strengthen community dynamics
- Advocate for an increase in the budget
- Redefine the nature of technical support

Medium and long term

- Improve coverage of interventions

- Improve staff training
- Rationalize their allocation and use

2.2. Human centered design approach

To obtain the expected results, the co-creation team opted for a human-centered method: "Human Centered Design" (HCD).

The HCD process broadly examines an ecosystem in which a program, initiative or service exists in order to understand exactly who is involved throughout the life of that program, service or initiative. It focuses on the needs and motivations of end users benefiting from technical support.

The goal of this method is to take into account the point of view of all the actors in order to imagine solutions together that work.

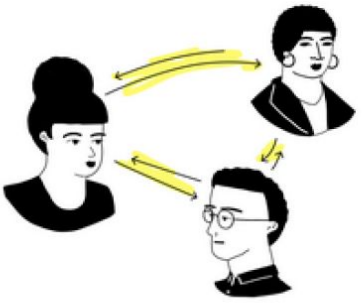


Figure 2: Illustration of the HCD method

2.2.1 Technical support implementation process

The work to design the new technical support model in the DRC took place in several stages, grouped into two main phases.

First work phase

During this phase, several approaches have been used (see Table 4). The focus was on (i) understanding the nature of the relationships between technical support providers, the government, donors and the community; (ii) strengthen knowledge on the various typologies of technical support in the DRC; (iii) identify the common and key points to these initiatives as well as the bottlenecks.

Table 4: Methodological approaches used according to the stages of the first work phase

Period	Approaches
August 2018	Document review on child health
November 2018	Anthropological survey based on interviews with the various stakeholders in technical support and beneficiaries to identify their experiences and perceptions
March 2019	First co-creation workshop to develop hypotheses
May 2019	Second co-creation workshop for the conceptualization of ideas and concepts and the definition of next iterative stages
June-July 2019	Reorientation of the project by including maternal health and HSS

Photos of a site visit to Mont-Ngofula I health zone to prototype concepts with the community

Second work phase

The second phase consisted of exploring in more depth the design principles, solidifying the feasibility and the viability of the concepts and creating a roadmap for change.

Table 5: Methodological approaches used according to the stages of the second work phase

Period	Approaches
September – October 2019	**Alignment of the Co-Creation team** • Review of data from previous phases and gaps and missing perspectives
October 21-26, 2019	**Immersion** (Launch workshop with the co-creation team, JSI and Sonder) • Collection of missing perspectives, interviews with decision makers and iteration and prioritization of results with the Co-Creation team
October – November 2019	**Reframe the opportunities** • Continued remote interviews to fill the remaining gaps then combining of the results • Review and refinement of the opportunity areas and the technical support blueprint
December 6-11, 2019	**Co-create** with Government representatives at all levels and key technical and financial partners • Generation of ideas based on design principles and the technical support blueprint • Prioritization of concepts
January - February 2020	**Definition of the roadmap** • Refinement of the priority concepts and creation of a roadmap for change, strategies and design principles defining clear actions to be undertaken by stakeholders
March 5-7, 2020	**Integration workshop** • Presentation of the roadmap, strategies and design principles for the DRC • Identification of the steps to follow for the implementation of these recommendations • Collection of general feedback on the HCD process and the project

Photos of the co-creation workshops

2.2.2 Actors involved in the process

The Co-creation workshops on the technical support model in the DRC were attended by several experts from various institutions, namely:

* The Ministry of Health (Directorates and Programs linked to RMNCAH+N);
* Technical support providers (NGOs /implementing agencies, CBOs);
* Users of technical support (health workers, beneficiaries, health center managers)
* Technical and financial partners: The "*Child Health Task Force*" as the framework initiative for this work, *JSI* on behalf of the Secretariat of the "Child Health Task Force" and beneficiary and coordinator of this grant, *Sonder Collective* as facilitator of the co-creation process and responsible for the design of the model.

RESULTS OBTAINED AND ANALYSIS

The results presented in this section relate to (i) the analysis of anthropological knowledge on the different typologies of technical support, (ii) the analysis of the challenges of the technical support concept, (iii) the identification of areas of opportunity, (iv) design principles and areas for change and (vi) creating a road map for implementing technical support.

3.1. Anthropological knowledge analysis

During the first phase, nine major anthropological findings were grouped into six concepts that were developed and prototyped at all levels of the system depending on the type of support (see Table 6).

Table 6: Prototyping of the concepts by level of the system and by type of support

Type of support	Health zone and community	Provincial	Central level
Systemic and political	Concept 1- Improve the planning and the follow-up of the activities according to the needs defined by the community	Concept 4 - Advocacy platform made up of multisectoral pressure groups aimed at decision-makers	
Technical	Concept 2 - Tools for collecting information at the community level and for the community to organize itself in structured groups Concept 3 - Community cooperative/Pooling of care adapted to community dynamics	Concept 6 - A mapping initiative so that information flows upwards	Concept 5 - A mapping initiative to coordinate curative, promotional and awareness-raising activities

After reviewing the data of the first phase, the co-creation team collected, during the immersion stage, the gaps and missing perspectives to finally prioritize the results in 19 concepts, grouped into 4 areas (see Table 9 in the appendix relating to conceptual solutions).

3.2. Analysis of the challenges to the concept of "technical support"

3.2.1. Redefining the concept of technical support

The term "technical support" is extremely broad and different development institutions often work with similar and overlapping definitions. The usual priority of interventions in this area, namely improving "capacities", "skills" and / or "performance", also covers a wide range of definitions and conceptualizations. The objective of technical support intervention can itself be far-reaching. Interventions can focus on improving the capacity of specific key individuals, or have a more ambitious goal by upgrading the functions of certain teams, set of systems and even entire organizations.

Box 1: Definitions of the concept of technical support according to the key actors of the health system in DRC

According to donors:
- *"Technical support is an integrated approach to the health system to meet the needs of the country."*

According to multilateral partners:
- *"Technical support should not be imposed, it should be useful and in line with the country's priorities."*
- *"The future of technical support is the proper identification of the overall problem, the sharing of terms of reference (TORs) between partners and validation with the government, and the provision of a solution."*

According to bilateral partners:
- *" Technical support is working together, sweating together, and not just about success. It's also failure."*
- *" Partnership, collaboration and communication are of the utmost importance. "*

- *"Sitting with the ministry is what technical support should be to make sure everything is coordinated and to provide appropriate support. "*

According to officials from the Ministry of Health:

- *" Technical support gets value if the receiving hand is also ready to accept it. We should have justification clear for any technical support coming from outside. "*
- *" Technical support must be rational and have added value. The future is strong leadership and provincial tools adopted. "*

Ultimately, after participative exchanges, the Co-Creation team redefined technical support as: ***"empowering local teams to fully play their role. This capacity building includes technical (knowledge), materials (equipment, inputs, consumables), and financial (transport, premiums, and financing of activities) aspects."***

3.2.2. Identification of technical support problems and analyses

The analysis of the operational capacity of the MOH reveals an enormous insufficiency in the conduct and implementation of the national health policy. Thus, technical support appears for the moment, as an alternative, no less negligible, in supporting the MOH to:

* Facilitate the strengthening of the MOH leadership to implement health policies;
* Contribute to the mobilization of resources (financial, human, logistical, etc.) to carry out interventions;
* Provide technical support to improve the quality of services offered;
* Stimulate demand and use of health services.

However, in reality, several questions influence the demand for technical support by the MOH and the supply of it by donors / partners. These include:

* Lack of awareness and insufficient agreement between donors and the Government on what is considered "technical support," and on potential supply;
* In several examples in the DRC, there is a lack of consensus between donors and the Government on what is meant by "technical support";
* In some cases, the technical support offered is not what the Government would ideally want, and the potential supply from donors is poorly understood;
* Wider relationships between the Government and donors influence the implementation of technical support on the ground;
* Deterioration in the general level of trust between donors / partners and the Government negatively affects the nature of technical support offered. Some partners / donors have withdrawn their support from the general (ministry) budget and have turned to project-based approaches;
* The use of national systems, in accordance with the commitments made in the Paris Declaration, can improve the appropriation of technical support interventions by the Government; however, sometimes donor systems are preferred. Granting technical support through Government systems improves government ownership, but donors often refuse to adhere to this approach;
* The individual characteristics of the technical support provider and the creation of a climate of trust are very important for technical support to be effective.
* Activities to raise the accountability of technical support, on the one hand to the Government and the community and on the other hand to donors, are important but it is often problematic to report to two different organizations.

Analysis shows that these facts corroborate the results of Kalambay and Van Leberghe.

In summary, according to the decision-makers, the problems of technical support reside, among other things, in the absence of results, harmonization, and a sustainability plan, as well as in the almost total dependence of the Government on external aid (technical support replaces the State), as illustrated in Box 2.

Box 2: Technical support problems according to the key actors in the DRC health system

- ***According to the donors:***
  - ✔*"Technical support has become a substitution for the government."*
  - ✔*"Weak leadership is not in a position to make a strong decision related to donors."*
- ***According to multilateral partners:***
  - ✔*"Technical support is a solution but also a problem. Without this, countries do not really progress, but it still does not provide results."*
- ***According to the bilateral partners:***
  - ✔*"There are no issues with technical support. There is a problem with the way we approach it. We don't take risks, we only wait for success. By doing this, we do not learn from our mistakes. "*
  - ✔*" We focus too much on the process rather than the impact; more on quick fixes than accountability. "*
- ***According to officials from the Ministries of Health:***
  - ✔*"The basis of technical support is false in the DRC. Donors all intervene in a different way: there is no harmonization ".*
  - ✔*"Leadership is a problem. Every project should have a sustainability plan. The State often struggles to support projects."*

3.3. Identification of areas of opportunity

Three critical areas of opportunity have been identified in which decision-makers can intervene to create a change in the health ecosystem in the DRC. These are:

* ***Rethinking interactions to strengthen local ownership and support strategic decision-making***
  Change the way in which the actors of the system interact, share, and make decisions with each other to equitably distribute the development of the priorities addressed and to strengthen the country's leadership.

* ***Rethink feedback circuits and data sharing processes to support contextualization and decentralization***
  Change the way information flows between different actors in the system to promote more informed decision making based on the local context.

* ***Rethink incentives and budgeting structures to strengthen the health system***
  Modify existing incentive and budgeting structures so that resources are used more efficiently and in a more balanced way and promotes the collective good rather than individual gains.

3.4. Design principles and domains of change for technical support

The design principles and concepts have been grouped into four domains of change. These should be seen as a system to be implemented to resolve the underlying problems the domains address and which would encourage the MOH to take responsibility for the long term benefit.

One domain of change addresses a systemic and political theme that affects the technical support system. The concepts and design principles are systemic in principle but technical in nature requiring a series of reforms, restructuring, and strengthening to successfully ensure the government process and more streamlined relationships with donors, partners, and communities.

Table 7: Principles and domains of change for technical support in the DRC

Domains of change	Principles to be respected
1. **Optimize finances to build for the long term**	* Direct funding to the zone level by providing support at national and provincial levels. * Minimize the duplication of funding for health zones and the dispersion of funds. * Optimize spending and encourage the strengthening of base structures and the improvement of infrastructure. * Implement an initiative system that promotes the State and stakeholder accountability.
2. Support to foster governance	* Align with common goals and priorities. * Allow the country to lead the technical support while respecting the rules of engagement. * Do not execute but accompany, with respect. * Avoid a cookie cutter approach. Adapt technical support to the context.
3. Cultivate collaboration and transparency between all actors	* Disseminate strategic decisions at all levels. * Share lessons learned on vertical and horizontal platforms. * Identify, socialize and reward success. * Strengthen accountability by aligning with the needs of beneficiaries. * Ensure joint evaluation of technical support services.
4. Reduce dependencies in favor of sustainability	* Build for financial sustainability after the departure of donors at national and local levels. * Increase state budgetary allocations for health. * Develop local resources (material, financial) even if that means sacrificing some immediate gains. * Encourage communities to take ownership of projects.

3.5. Creation of the roadmap / recommendations and conceptual solutions

Table 8: Recommendations of the roadmap for technical support by domains of change in the DRC

Responsibility level for concepts	Recommendations by domains of change			
	Domain 1	**Domain 2**	**Domain 3**	**Domain 4**
Overall recommendations for technical support	* Foster infrastructure development	* Multisectoral support (and mandatory consultation framework)		* Sustainability plan for initiatives * Investment plan for sustainability of initiatives
Country recommendations for technical support	* Update the map of interventions	* Review of TORs for resident technical assistants and permanent provincial supervisors * DRC procedure manual * Update the map of interventions	* Mandatory consultation framework * Dashboard of strategic decisions	* Investment plan for the sustainability of initiatives (State) * Reinforce the Inspectorate for Health (IGS) and the Provincial Health Inspectorate (IPS)
Recommendations for the State	* Update the resource mobilization plan			* Pooling of care adapted to community dynamics * Motivating volunteers and service providers

Conceptual solutions by priority domains of change

It is obvious that good respect for the country's priorities can contribute to strengthening the system. All of this depends on strong State leadership. However, it is weakened for various reasons mentioned above. Details concerning the description of solutions, limits, and advantages for each concept can be found in the document "Re-imagining technical support in the DRC," page 35-80.

CONTRACTUAL, M&E, AND ACCOUNTABILITY FRAMEWORK

4.1 Contractualization

4.1.1 Areas of partnership

According to the "Vademecum of partnership in the health sector" published in 2002 by the MOH, the main areas of partnership envisioned are:

- ✔ Institutional or operational support at all levels of the health system;
- ✔ The integration of private healthcare establishments into the National Health Policy;
- ✔ Integration of primary health care activities in privately owned health facilities;
- ✔ The transfer of management of public medical establishments to private ones (devolution of public service);
- ✔ Support for public structures in the form of financing certain specific activities and sponsorship or partial or global support;
- ✔ Support to schools and health science teaching institutes;
- ✔ The integration of private pharmacies, support to drug purchasing centers and partnership with wholesalers.

4.1.2 Contract approach

The contract approach is a tool for implementing the National Health Policy, with the aim of improving the management of the populations' health problems.

Rather than passively witnessing the uncontrolled development of multiple, diverse, and difficult to control activities of private actors - for profit or not (NGOs, faith-based organizations) - the State can strengthen its normative and centralizing role, guarantor of the population's health while involving potential partners in the implementation of its health policy.

- The contract approach is essential: the contract application is organized at an operational partner of the State for the provision of public health services.
- It means for the MOH: an opportunity to improve the provision of health services with the motto "neither privatization nor disengagement."
- Its field of application is as broad as possible: it is defined by negotiation and carried out in collaboration and can relate either to specific services, to support, to accompaniment, up to the co-execution of certain tasks and missions.

The contract approach goes through the following stages:

- The definition by the Ministry of its needs and the choice among them of priorities;
- The identification of the actors in the field of health and potential partners of the State;
- The definition of their legal status;
- Internal awareness;
- The negotiation of the obligations of each party; and finally,
- The signing of formal agreements (contracts) by writing down the parties, roles, objectives, requirements, and obligations of each.

The contract approach invites the MOH to integrate contracting as a systematic mode of operation; not standardized, but planned.

4.1.3 "Single contract" as a tool for coordinating external health aid

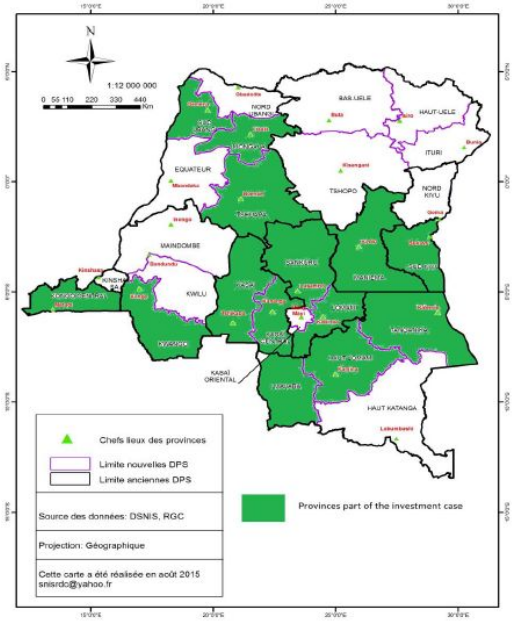
A study carried out by the MOH-DEP has shown that: (i) all DPS, central directorates and specialized programs have several contracts and some have up to 30 contracts with various partners, (ii) funding at the intermediate level is very fragmented, (iii) the funding methods targeting either individuals or

one-off activities show duplication, and (iv) waste and overlapping support do not promote institutional development.

To change this situation, in December 2014, the MOH adopted the single contract as a national tool for channeling funding and encouraging a performance-based results framework. The establishment of a single contract with a performance framework aligned with the missions of the directorates, programs, and DPS should make it possible to better coordinate external support and strengthen the leadership of the MOH. This tool aims to establish sufficient and regular structural funding on the one hand, and on the other hand to gradually absorb the multiple contracts that currently exist in health institutions. The single contract makes it possible to gradually absorb the fragmented financing of the partners.

As part of strengthening official development assistance, the DRC signed the Partnership Charter in 2014 in which all partners made a commitment to harmonize their interventions within the sector. This was realized by the signing of several memorandums of understanding, but also by the establishment of a multi-donor platform as part of the preparation of the Health System Development Project (PDSS).

4.2 Location of priority provinces for technical support



As mentioned above, technical support will focus first on the 14 priority provinces selected in the Investment Framework, based on criteria looking at the greatest needs for RMNCAH+N (neonatal mortality, malnutrition, early pregnancy, family planning), the health system (medicine, human resources, and civil society), and the socio-economic environment (level of poverty).

The provinces are Tanganyika, Haut-Lomami, Sankuru, Maniema, Lomami, Tshuapa, Kongo Central, Sud-Kivu, Kasai, Kasai-Central, Lualaba, Mongala, Sud-Ubangi, et Kwango (see Figure 3). Following these, technical support will gradually reach the other provinces for full coverage and achievement of the SDGs.

Figure 3: Location of priority provinces for technical support in DRC (source: Investment Framework 2017-2021)

4.3 Link between technical support and country strategic documents

As technical support is an innovative approach and not parallel to the DRC health system, there are close links between the concepts and fields created in this approach and the axes, priorities, or packages of existing strategic documents in the country, among others the 2019-2022 PNDS, the Investment Framework, the Health Financing Strategy, the Single Contract, as described in Table 9 below:

Table 9: Link between technical support and the country's strategic documents

Strategic Documents		Technical Support Approach			
		Domain 1	***Domain 2***	***Domain 3***	***Domain 4***
PNDS 2019-2022	*Axis 1: Improvement of health service delivery and continuity of care*	Concept 1.3 Concept 1.5		Concept 3.4	Concept 4.2 to Concept 4.4
	Axis 2: Support to the various pillars of the health system	Concept 1.2 Concept 1.4		Concept 3.1 Concept 3.2	
	Axis 3: Strengthen governance and the health system	Concept 1.1 Concept 1.6	Concept 2.1 to Concept 2.4	Concept 3.1 to Concept 3.4	Concept 4.1
Investment Framework	*Package 1: Implementation of priority RMNCAH services as well as services intended for survivors of SGBV*	Concept 1.1			Concept 4.3 Concept 4.4
	Package 2 : Methods for implementing priority RMNCAH services	Concept 1.4 Concept 1.5		Concept 3.1 Concept 3.4	Concept 4.4
	Package 3: Strengthening the health system to support the implementation of priority RMNCAH services	Concept 1.1 to Concept 1.6	Concept 2.1 to Concept 2.4	Concept 3.1 Concept 3.2 Concept 3.3	Concept 4.1 and Concept 4.2
Health Financing Strategy	*Priority 1: Mobilization of sufficient and sustainable resources to finance the supply and demand of health services*	Concept 1.4	Concept 2.4		Concept 4.3
	Priority 2: Reduce the fragmentation of health financing for broader and equitable care	Concept 1.6		Concept 3.5	
	Priority 3: Reduce the financial barriers to access quality health services			Concept 3.4	
	Priority 4: Optimize the use of resources in the health sector	Concept 1.1 to Concept 1.6	Concept 2.1 to Concept 2.4	Concept 3.1 Concept 3.3	Concept 4.1
Single contract	*Coordinate financing*			Concept 3.1 Concept 3.3	
	Harmonization and alignment		Concept 2.2		
	Avoids duplication of interventions and strengthens management		Concept 2.3	Concept 3.2 Concept 3.3	Concept 4.1
	Virtual basket fund	Concept 1.1		Concept 3.3	Concept 4.1 Concept 4.2
	Accountability and transparency			Concept 3.1 Concept 3.5	
	Closes the gaps with better allocation of funds		Concept 2.1	Concept 3.3	
	Strengthens decentralization	Concept 1.3			Concept 4.1 Concept 4.2
	Structural financing	Concept 1.1	Concept 2.4	Concept 3.3	

	Traceability and mobilization of domestic funds aligned with DPS priorities		Concept 2.3		

Given that technical support focuses on the priorities of the Investment Framework, which aligns with the priorities of the PNDS, the technical support M&E framework will be the same and will focus on the key indicators of the Investment Framework in harmony with that of the PNDS. Thus, the M&E mechanisms of technical support (like the Investment Framework) will be similar to those of the PNDS CSE 2019-2022 and will not give rise to parallel activities, except for a few adaptations.

In order to effectively harmonize the various M&E activities at all levels of the healthcare pyramid, good coordination is necessary. The latter will be based on regular meetings involving all stakeholders at all levels of operation. Pending the process leading to the validation of technical support documents and tools including the roadmap (see Annex), some follow-up activities can be done including continuous monitoring of phases, an annual review to analyze progress, and presentation of results to the CNP-SS.

A Technical Support Coordination Committee will be set up around the DEP. The focal point of the Co-creation Team, the Director of PNIRA, will work in close collaboration with the Central Directorates - mainly DSFGS, programs, and technical and financial partners in connection with the SRMNEA. With this, the Co-creation Team can help the DEP to perfect the process of implementing technical support.

As for technical support indicators, the 2019-2022 PNDS M&E Framework will serve as a basis for monitoring the implementation of this approach at the national level.

PERSPECTIVES ON THE MAP OF INTERVENTIONS AND PARTNERS

In the DRC, several partners support the health sector. Their contribution represents 40% of health funding. Efforts to coordinate and harmonize partner interventions are being made through the Inter-Donor Health Group (GIBS), which must gradually integrate the Sectoral Coordination Committee. The main donors are Belgium, Canada, the United States of America and Great Britain. The multilateral partners are the European Union, the World Bank, the African Development Bank, the Global Fund, and GAVI.

The mapping of interventions and partners provided is a proposal for orienting the domains of change by partners and provinces for the period of 2020 to 2022. The targeted provinces are the 14 priority provinces of the Investment Framework.

5.1. Proposal for funding map by domains of change and partners

Table 10: Funding map by domains of change and partners

Technical Support Priorities / Invest Framework	2020-2022	MOH	Private non-profit	Partner 1	Partner 2	Partner 3	……	Total	Gap
Optimize finances and build for the long term									
Support to foster governance									
Cultivate collaboration and transparency between all actors									
Reduce dependencies in favor of sustainability									
Total									
Percentage									

5.2. Proposal for a funding map by domains of change and province

Table 11: Funding map by domains of change and province

Technical Support Priorities / Investment Framework	2020-2022	Tanganyika	….	….	….	….	….	……	Total	Gap
Optimize finances and building for the long term										
Support to foster governance										
Cultivate collaboration and transparency between all actors										
Reduce dependencies in favor of sustainability										
Total										
Percentage										

CONCLUSION

During this process of alignment, immersion, co-creation, and development of the roadmap for change, technical support in the health sector was understood by stakeholders as empowering local authorities to fully play their role under the asserted authority of the State, with the support of local and external partners, particularly in areas where needs are not covered by the State. This implies strong leadership, good governance, a collaborative and transparent approach, value for money to reduce dependence and build for the long term.

Four domains of change have been identified and recommendations, as well as recommended solutions, must be implemented while respecting the service principles according to the roadmap developed. Alignment with the real needs anticipated by the beneficiaries, the harmonization of the assistant-assisted pair, compliance with the contractual framework, M&E and accountability as well as the mapping of interventions and stakeholders, are necessary for the success of this innovative approach.

As such, this project can be understood as “Re-imagining technical support in the DRC” in favor of maternal, newborn, child and adolescent health - including nutritional aspects and health systems strengthening.

Photos of the integration workshop, with the involvement of the Secretary General of Health, at the Rotana Club Plaza Hotel, March 2020

APPENDICES

Appendix 1: Roadmap for the next steps

N°	Activities	Lead	Timeline (March 2020 - September 2021)												Assumptions	Approx. costs
			03	04	05	06	07	08	09	10	11	12	..	09		
1	Organize an adaptation workshop (deliverable: consolidate the report in line with the country format based on the PNDS investment plan and the UHC strategic plan)	Co-creation team													Presidency (2), Cabinet (1), SG (1), DEP (1), DGOSS (1), Co-creation team (15), Support staff = **Total 25 pers.** **5 days of residential workshop in Kinshasa**	$ 29,000
2	Submission and validation of documents by a group of independent experts (to be identified). Possible options: DEP documentation commission; private institutions, consultants or universities.	Co-creation team													Cost of four experts for seven days	$ 7,000
3	Organize 2nd workshop (deliverable: development, harmonization and production of various tools of technical support to accompany validated documents)	Co-creation team													See assumption # 1	$ 29,000
4	Adoption of materials and tools by the Governance Committee	Governance Committee													Costs of printing documents and tools (contracts	$ 5,000

															and procedural tools)	
5	Transmitting documents and tools to the CLC	Governance Committee														
6	Validation of documents and tools by the CCT	SG														
7	Documents and tools brought to the CNP-SS and validated as political documents, ready to be disseminated	SG													In case of changes, printing costs	*Included in step 4*
8	Dissemination of documents and tools in 26 provinces	SG													Cost of printing documents and tools (contracts and procedural tools)	$ 15,000
9	Set up a technical support follow-up committee (transform the co-creation team into a follow-up committee) around DEP	SG													Quarterly meeting, cost for 10 people	$ 1,000
10	Continuous monitoring of progress/stages	SG														
11	Annual progress review meeting (one year after step 7) and present review results to the CNP	SG													26 Provincial representatives + NC = ~ **60 pers. [cost of travelers + per diem, room + individual transport, 2 days of workshop, printing]**	$ 45,200
															Subtotal: $ 131,200	
															Contingencies: 10%	

Appendix 2 : List of experts who participated in the Re-imagining Technical Support in DRC process

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