Evaluation

Performance Evaluation of USAID's Integrated Health Program in the Democratic Republic of Congo

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USAID FROM THE AMERICAN PEOPLE

DATA FOR impact

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Janna Wisniewski,[1,2] David Hotchkiss,[1,2] Lauren Blum,[1,2] Jonathan Niles,[1,2] Steven Dominguez, Jr.,[1,2] Savannah Badt[1,2] Paul-Samson Lusamba-Dikassa,[1,2,3] Eric Mafuta,[3] Anicet Yemewni,[4] Marc Bosonkie[3]

[1] Data for Impact [2] Tulane University

[3] Kinshasa School of Public Health [4] Independent consultant

Data for Impact

University of North Carolina at Chapel Hill
123 West Franklin Street, Suite 330
Chapel Hill, NC 27516 USA

Phone: 919-445-6949

D4I@unc.edu
http://www.data4impactproject.org

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Abstract

This report presents findings from a performance evaluation of the United States Agency for International Development's (USAID) Integrated Health Program (IHP) in the Democratic Republic of Congo. The evaluation, conducted by Data for Impact, assessed the program's effectiveness in achieving its objectives: strengthening health system governance, increasing access to integrated health services, and promoting healthy behaviors. The evaluation focused on four research questions: Did the expected changes in outcomes and impacts occur? To what extent were changes in healthy behaviors attributable to USAID IHP? Did the project contribute to gender equity in health services? What factors enabled or limited the program's success?

Using both quantitative and qualitative methods—including surveys, interviews, and focus groups—the evaluation found that USAID IHP made progress in governance and service delivery, especially in maternal health, tuberculosis, and malaria. However, such challenges as high staff turnover, political instability, and limited government ownership hindered sustainability. USAID IHP contributed to gender equity by increasing women's leadership in health committees. The report highlights the need for continued focus on health worker training, integrated service delivery, and system-wide improvements in referral systems and financing models to ensure long-term success.

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Abbreviations

AAP	Agence d'Achat de Performance (World Bank Performance Purchasing Agency)
ACT	artemisinin-based combination therapy
ANC	antenatal care
BA	Breakthrough ACTION
BCG	Bacillus Calmette-Guérin
BCP	bulletin communautaire de performance (community scorecard)
BCZS	Bureau central de la zone de santé (central office of the health zone)
BEmONC	basic emergency obstetric and newborn care
CAC	cellule d'action communautaire (Community Action Committee)
CDR	Centre de Distribution Régionale (Regional Distribution Center)
CEmONC	comprehensive emergency obstetric and newborn care
CF	Congolese Franc
CHW	community health worker
CODESA	Comité de Développement de l'Aire de Santé (health area development committee)
COGE	comité de gestion (management committee)
COVID-19	coronavirus disease 2019
CPN	consultation prénatale (prenatal consultation)
CPON	consultation postnatal (postnatal consultation)
CPS	consultation préscolaire (preschool consultation)
CSO	civil society organization
D4I	Data for Impact
DHIS2	District Health Information Software, version 2
DPS	Division Provinciale de Santé (Provincial Health District)
DRC	Democratic Republic of the Congo
EU	European Union
FGD	focus group discussion
FP	family planning
FY	fiscal year
HA	health area

HC	health center
HCD	human-centered design
HGR	Hôpital Général de Référence (General Reference Hospital)
HPHA	high-performing health area
HPHC	high-performing health center
HZ	health zone
ICCM	integrated community case management
IHP	Integrated Health Program (in French PROSANI USAID)
iHRIS	iHuman Resources Information System
IMCI	integrated management of childhood illness
IP	implementing partner
IPS	Inspection Provinciale de la Santé (Provincial Health Inspectorate)
IPT	intermittent preventative therapy
IPV	inactive poliovirus vaccine
IT	infirmière titulaire (registered nurse/head nurse)
IUD	intrauterine device
IYCF	infant and young child feeding
LPHA	low-performing health area
LPHC	low-performing health center
LPHZ	low-performing health zone
MAPEPI	maladies à potentiel épidémique (diseases with epidemic potential)
MCH	maternal and child health
MCZ	Médecin Chef de Zone (Chief Medical Officer)
MNCH	maternal, neonatal, and child health
MOH	Ministry of Health
NGO	nongovernmental organization
OPV	oral polio vaccine
PAO	Plan d'Action Opérationnel (Annual Operations Plan)
PBF	performance-based financing
PCV	pneumococcal conjugate vaccine
PICAL	Participatory Institutional Capacity Assessment and Learning Index

PMTCT	prevention of mother-to-child transmission
PP	percentage point
SBC	social and behavior change
SGBV	sexual and gender-based violence
SNIS	Système National d'Information Sanitaire (National Health Information System)
SP	sulfadoxine-pyrimethamine
TB	tuberculosis
TIP	trafficking in persons
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WASH	water, sanitation, and hygiene
WHO	World Health Organization

Executive Summary

This report presents the findings of a performance evaluation of the United States Agency for International Development's (USAID) Integrated Health Program (IHP) in the Democratic Republic of the Congo (DRC) conducted by Data for Impact (D4I). The USAID IHP was launched in July 2018 and implemented over seven years across nine provinces in the DRC, with the aim of improving health systems and increasing access to health services. The evaluation assessed the program's effectiveness in achieving its objectives, strengthening governance, and enhancing health outcomes.

Purpose and Background

The performance evaluation was conducted to assess USAID IHP's progress in strengthening the DRC's health system governance, improving access to quality health services, and promoting healthy behaviors. The report focuses on the program's three objectives:

1. Strengthen health systems governance and leadership at provincial and facility levels.
2. Increase access to quality integrated health services in targeted health zones (HZs).
3. Promote the adoption of healthy behaviors, including increased use of health services.

The program's interventions focused on key health areas: family planning (FP), immunization, malaria, maternal and child health (MCH), nutrition, tuberculosis (TB), and water, sanitation, and hygiene (WASH).

Evaluation Questions

The evaluation addressed four questions:

1. Did the expected changes in outcomes and impacts occur?
    a. Strengthen health systems, governance, and leadership at provincial, health zone (HZ), and facility levels in target HZs.
    b. Increase access to quality, integrated health services in target HZs.
    c. Increase adoption of healthy behaviors, including health service use, in target HZs.
2. If there were changes in healthy behaviors over the course of the study period, to what extent were they attributable to USAID IHP?
3. Did the project contribute to gender equity in health services and in the health system?
4. What factors enabled or limited the success of USAID IHP?

Methods

The evaluation used both quantitative and qualitative methods, including:

- Surveys of health workers, HZs, facilities, and community health workers (CHWs) conducted in three waves (baseline, midline, and endline) across the program's nine target provinces.
- Key informant interviews with USAID IHP personnel, government officials, and health workers.
- Focus group discussions (FGDs) with community members, especially mothers and guardians of children under five.

Key Findings

Research Question 1: Did the expected changes in outcomes and impacts occur?

The performance evaluation revealed that USAID IHP made significant strides in strengthening health systems governance, improving access to health services, and enhancing the adoption of healthy behaviors. The program's use of tools, like the Participatory Institutional Capacity Assessment and Learning Index (PICAL), led to measurable improvements in governance and leadership at the provincial and HZ levels. From 2019 to 2024, the use of PICAL assessments at HZ offices showed improvements, with participation increasing by 20 percentage points across the nine provinces. This enhancement was largely attributed to the introduction of better strategic planning processes, improved communication, and targeted leadership training. However, persistent challenges, such as high staff turnover and political instability, especially in provinces like Tanganyika, undermined the continuity of leadership and hindered the full potential of these improvements.

USAID IHP's efforts to increase access to quality health services also demonstrated positive outcomes. The program invested in infrastructure, medical supplies, and extensive training of health workers, especially in such areas as maternal health, child health, TB, and malaria. For example, emergency obstetric care improved significantly through the introduction of clinical mentoring sites, where health workers received hands-on training in life-saving delivery practices. In addition, the program's malaria and TB interventions led to better diagnostic capabilities, with increased detection rates and high recovery rates, including more than 80 percent for multi-drug-resistant TB cases.

Community-based care sites were established to provide basic health services in remote areas, focusing on treating common childhood illnesses. Although these sites expanded healthcare access, especially for vulnerable populations, concerns about the quality of care persisted in areas where infrastructure and security issues remained significant barriers to effective service delivery.

Research Question 2: To what extent were changes in health behaviors attributable to USAID IHP?

The impact evaluation of USAID IHP—the results of which are presented in a separate report[1]—showed small but mostly positive changes in Routine Health Information System (RHIS) indicators, with 11 of 13 indicators moving in the desired direction (Data for Impact, 2024). Five of these indicators demonstrated significant differences between intervention and comparison facilities, especially in the uptake of modern contraception, which saw the greatest impact. Smaller improvements were seen in the provision of insecticide treated nets at antenatal care (ANC) visits, treatment of diarrhea, and measles vaccinations. However, indicators for complicated malaria treatment and malnutrition prevention showed negative trends, warranting further investigation to understand whether the results reflected treatment effectiveness or gaps in care.

Research Question 3: Did USAID IHP contribute to gender equity in health services?

USAID IHP made notable contributions to promoting gender equity in the DRC's health system. One of the key successes was the increased participation of women in leadership roles in health committees and CHW networks. More than 40 percent of *cellules d'action communautaires* (CACs, Community Action Committees)

that were revitalized by USAID IHP were led by women by the end of the program, marking a significant step toward gender parity in local health governance. The program also promoted gender-sensitive recruitment and training of health workers, which led to more female CHWs being involved in service delivery.

To further integrate gender equity in health services, USAID IHP established gender units in all provincial health offices and several HZs. These units were tasked with addressing gender disparities in healthcare access and decision making. The program also encouraged the promotion of female health workers and the integration of gender considerations in health policy.

Research Question 4: What factors enabled or limited the success of USAID IHP?

Several factors contributed to the success of USAID IHP. The program's focus on providing technical assistance and training to health workers and government officials at various levels played a critical role in improving health system governance and service delivery. Tools like the PICAL and InfoMED systems (a comprehensive logistics management information system for commodity management that captures patient data and triangulates them with data on drug availability) enabled more effective management of resources and data, contributing to better decision making at health facilities. Moreover, community engagement through *Comité de Développement de l'Aire de Santé* (CODESA; community health committee) and the use of *relais communautaires (*RECOs*,* i.e., CHWs) helped build trust in the health system and fostered a sense of local ownership of health services.

However, the program faced several limitations that impeded its full success. Political instability and high staff turnover in the program, especially at senior levels, disrupted the continuity of leadership and undermined long-term improvements in governance. In provinces such as Tanganyika and Sud Kivu, ongoing conflict and insecurity made it difficult to retain trained health workers and maintain consistent service delivery. Furthermore, limited government ownership of health interventions, coupled with underfunding, weakened the sustainability of the program's achievements. Despite efforts to improve government involvement, key informants noted that the engagement was low and the government's financial contributions to health services remained insufficient.

The motivation of health workers was another significant limiting factor. Low salaries and inadequate compensation, especially in remote provinces, led to frequent staff turnover and reduced morale. This problem was exacerbated by the nationwide nurses' strike in 2021, which significantly disrupted health services across five provinces and delayed progress in several program areas. In addition, logistical challenges related to the delivery of essential drugs and medical supplies—especially in hard-to-reach areas—further limited the program's impact.

Recommendations

Improving USAID IHP's Approach

In the case that USAID wishes to build on the design of USAID IHP in future investments, the following recommendations are offered.

1. Emphasize using PICAL results to guide management changes in HZs.
2. Increase the frequency and consistency of supervision visits at the operational level, ensuring the necessary resources for routine supervision.
3. Continue supporting managerial and technical meetings, such as comité de gestion (COGE,

management committee) for information sharing and collaboration.

4. Further integrate the community scorecard approach in routine management decisions at health facilities.
5. Improve the selection process for training participants and evaluate the effectiveness of the cascade training approach to enhance knowledge transfer.
6. Develop mechanisms to provide health workers in remote areas with regular access to updated health information, including the creation of an online platform.
7. Publicize accountability mechanisms more widely and ensure follow-up action on credible reports of corruption or malpractice.
8. Target efforts to improve the availability of low-prevalence services, such as TB treatment and comprehensive sexual and gender-based violence (SGBV) services.
9. Provide continued support for training health workers to properly use more sophisticated equipment.
10. Investigate the drug value chain to address irregular and delayed drug deliveries and adjust drug delivery approaches based on contextual factors.
11. Analyze the vaccine supply chain for each vaccine type to ensure continuous availability, especially for the Bacillus Calmette-Guérin (BCG) vaccine for TB.
12. Address underlying factors impacting health worker job satisfaction, especially remuneration, working conditions, and professional development opportunities.
13. Revitalize community scorecard training and provide consistent support for CODESA members to ensure sustained engagement.
14. Continue focusing on improving maternal and neonatal health technical skills, especially in diagnosing preeclampsia and managing labor.
15. Increase behavior change communication to address misconceptions about contraceptive use and target male partners in interventions.
16. Further emphasize service integration, including through integrated care protocols and supportive supervision.
17. Provide additional training and support to retain volunteer health workers and improve community health system functionality.
18. Institutionalize funding for CACs and CODESAs to ensure their sustainability.
19. Increase government buy-in for VIVA interventions (an innovative social and behavior change campaign) to enhance their impact.
20. Improve preparation and organization for mini-campaigns to ensure medication and commodity availability.
21. Increase monitoring and oversight of contracted local nongovernmental organizations (NGOs) to improve performance.

Suggested Future Directions

The following are suggestions for future directions for USAID support, beyond what was covered under the USAID IHP approach.

1. Improving connectivity at health facilities could enhance reporting, remote supervision, access to information, and online banking.
2. USAID could develop a resourced process for regular maintenance and repair of health facilities with the Ministry of Health (MOH) to improve facility conditions.
3. Future programs might explore health financing models to promote protection from catastrophic health expenditures for households and reduce stress on health facilities.
4. Research on barriers to referral acceptance could help improve referral systems, and mapping referral facilities could enhance understanding of service availability and distances.
5. Pre-service training could be strengthened to produce highly skilled health workers before they are deployed, and online continuing education could be explored.
6. Integrated supportive supervision and clinical mentoring could ensure that health workers maintain high service quality.
7. A tailored strategy to improve leadership and governance and service delivery at hospitals might be considered in future programs to address their unique needs and challenges.
8. An assessment of gender equity among health workers could help identify areas for improvement, such as pay, labor division, and professional opportunities.
9. Future investments in nutrition and WASH could be prioritized to address issues of acute malnutrition and severe diarrhea, especially considering the potential impacts of climate change.

Conclusion

The USAID IHP made substantial progress in improving health outcomes and strengthening health systems in the DRC. However, persistent challenges, such as political instability, inadequate government ownership, and health worker turnover, limited the program's overall impact. Continued efforts to build local capacity, enhance health worker motivation, and address socio-cultural barriers to healthcare access are critical for sustaining these improvements in the long term.

Evaluation Purpose and Questions

Evaluation Purpose

Data for Impact (D4I) carried out a performance evaluation and an impact evaluation of the United States Agency for International Development's (USAID) Integrated Health Program (IHP) in the Democratic Republic of the Congo (DRC). The results of the performance evaluation are presented in this report. Results of the impact evaluation are presented in a separate report, and are integrated in the discussion and recommendations sections presented later in this report. Performance evaluations incorporate before and after comparisons, but generally lack a rigorously defined counterfactual to control for factors other than the project or intervention that might account for the observed change. Impact evaluations assess the extent to which changes in health outcomes or service use over time are attributable to an intervention.

Research Questions

The specific research questions addressed in the evaluation were the following:

1. Did the expected changes in outcomes and impacts occur?
    a. Strengthen health systems, governance, and leadership at provincial, health zone (HZ), and facility levels in target HZs.
    b. Increase access to quality, integrated health services in target HZs.
    c. Increase adoption of healthy behaviors, including health service use, in target HZs.
2. If there were changes in healthy behaviors over the course of the study period, to what extent were these attributable to USAID IHP?
3. Did the project contribute to gender equity in health services and in the health system?
4. What factors enabled or limited the success of USAID IHP?

The impact evaluation addressed Research Question 2. This report presents the findings from the performance evaluation. The performance evaluation aspect of the study addressed:

- Research Question 1, which investigated changes over time in USAID IHP areas.
- Research Question 3, which examined the extent to which the project addressed issues of gender equity.
- Research Question 4, which investigated the factors that enabled or limited the success of the project.

Background

As part of its strategy to improve health outcomes in the DRC, USAID funded the USAID IHP in 2018. The program began operations in July 2018 and is being implemented over a seven-year period. USAID IHP works across nine provinces clustered in three regions in the country's southeast: Eastern Congo; Kasai; and Katanga. Abt Associates leads the project, with the International Rescue Committee and Pathfinder International serving as core partners. Seven niche partners with expertise in health programming, designing innovative approaches, and research in fragile states—including in the DRC—are also part of the project's consortium, including I+Solutions, Matchboxology, BlueSquare, Mobile Accord/Geopoll, Training Resources Group, and Viamo.

The purpose of USAID IHP is to strengthen the capacity of Congolese institutions and communities to deliver high-quality, integrated health services to sustainably improve the health status of the country's population. The specific health, population, and nutrition areas of focus for the project are maternal health; neonatal, infant, and child health; tuberculosis (TB); malaria; child nutrition; water, sanitation, and hygiene (WASH), and family planning (FP). USAID IHP works in nine contextually diverse provinces in the regions of Eastern Congo, Katanga, and Kasai, and implements a wide array of interventions, as described later in this section.

Given the breadth and depth of the planned interventions, the USAID Mission in the DRC requested D4I to conduct an independent, third-party evaluation of the performance and impact of USAID IHP on key health systems-related outcomes, including the uptake of FP and health services; health systems functioning (i.e., improved disease surveillance, the availability of essential commodities, and health worker motivation); and the practice of key healthy behaviors.

In the remainder of this section, we describe the country and health systems context for the evaluation and the objectives and programmatic approaches planned at the project's beginning. It should be noted that, in the results section, we include a description of how the project evolved over the seven-year implementation period based on a review of the projects' annual reports and on key informant interviews.

Country and Health Systems Context

Geographic, Economic, and Political Context

The DRC is the largest country in sub-Saharan Africa, rich in natural resources, such as minerals, forests, and arable land. Despite this, the vast majority of the population continues to live in poverty. The DRC had a gross national income per capita that was still one of the lowest globally, and about 74.6 percent of its population lived on less than 2.15 US dollars (USD) per day in 2023, reflecting the deep-rooted economic challenges (World Bank, 2024).

The long-delayed 2018 general elections were marked by controversy and allegations of fraud, highlighting the ongoing fragility of the country's electoral process. By 2024, President Tshisekedi had secured a second term, but forming a governing majority remains a challenge and insecurity worsens in North Kivu and Ituri. Despite strong gross domestic product growth of 7.8 percent in 2023, driven by the mining sector, agriculture lags and inflation and exchange rate depreciation strain the economy (World Bank, 2024).

Health System Context

The DRC's health system is structured across three levels: central, provincial, and peripheral (health zones [HZs]). Despite this organization, the health system faced severe underfunding, with government health

spending remaining low at around 4 percent of the national budget. This underinvestment meant that health services were largely sustained through out-of-pocket payments and development assistance for health. However, development assistance for health was heavily directed toward vertical disease-specific programs (such as malaria, HIV/AIDS, and immunization), often at the expense of comprehensive primary health services (World Bank, 2020).

Socially, the DRC faces severe challenges, with high child stunting rates, poor education quality, and gender inequality. Women are underrepresented in education and vulnerable to violence. The health system, weakened by conflict and the 2019 coronavirus disease (COVID-19) pandemic, struggles with outbreaks and vaccine hesitancy (World Bank, 2024).

Project Objectives

USAID IHP was tasked with working closely with government health officials at central, provincial, zonal, and health facility levels to build government capacity and leadership, and to increase the sustainability and local ownership of interventions. USAID IHP was designed to address three program objectives, as follows:

- Objective 1: Strengthen Health Systems, Governance, and Leadership at Provincial, Health Zone, and Facility Levels in Target Health Zones
- Objective 2: Increase Access to Quality, Integrated Health Services in Target Health Zones
- Objective 3: Increase the Adoption of Healthy Behaviors, including the Use of Health Services in Target Health Zones

Programmatic Approaches

Objective 1: Strengthen Health Systems, Governance, and Leadership at Provincial, Health Zone, and Facility Levels in Target Health Zones

The planned programmatic approaches related to Objective 1 were aimed to support provinces, HZs, and communities to become empowered stewards and effective managers of health system functions, via tailored needs-based interventions, guided by the results of Participatory Institutional Capacity Assessment and Learning Index (PICAL) evaluations and human-centered design (HCD) techniques.

Use of the PICAL tool at provincial and HZ levels aimed to foster a culture of self-assessment, enhance institutional capacity building, and guide the development and implementation of performance improvement action plans to support improved governance, leadership, and accountability. The capacity-building needs identified during PICAL assessments were intended to facilitate targeted technical assistance, coaching, and leadership training in (1) public financial management; (2) analysis and use of data for improved disease surveillance and facility-level data reporting; (3) management of human resources for health, taking gender into consideration in the recruitment and deployment of staff; and (4) use of a performance dashboard tool to equip provincial and HZ managers with real-time, data-driven, decision-making capabilities. Moreover, USAID IHP planned to optimize the use of existing methods, such as results-based financing; employing mobile phone-based surveillance technologies; and strengthening supply chain activities to support quantification, forecasting, and timely inventory replenishment.

At the community level, USAID IHP planned to use the Ministry of Health's (MOH) community dynamics strategy to improve coordination and oversight functions. By facilitating collaboration among provincial, HZ, and community entities, this strategy aimed to strengthen the capacity of *Comité de Développement de l'Aire de Santé* (CODESA; health area development committee), civil society organizations (CSOs), and community-

based organizations to be true partners in addressing social and behavior change (SBC), and mobilizing the demand for and uptake of improved health services. Activities to support community-level monitoring of health system performance were to include streamlining community scorecard approaches; launching a toll-free fraud and complaints hotline (number for reporting corruption, abuse, or similar allegations; and providing rights-based education to communities. Capacity building of CODESAs, select CSOs, or community-based organizations were also planned through a Grant under Contract program. Together, these approaches were aimed to enhance coordination capacity and multi-level collaboration to support more effective community stewardship of the health system, while demanding accountability of both local and provincial authorities.

Objective 2: Increase Access to Quality, Integrated Health Services

The programmatic approaches related to Objective 2 were to focus on increasing health service demand, access, and quality in the program's regions. A primary component was to entail scaling up health facilities that can provide essential, integrated, and high-quality health services. Facility-based activities were to include renovating health infrastructures; equipping health facilities with drugs and medical supplies; and building knowledge and capacity among health workers so that health personnel can provide a package of integrated services for maternal, neonatal, and child health (MNCH); nutrition; FP and reproductive health; WASH; malaria; and TB.

The planned interventions were also to be focused on improving health worker attitudes and interpersonal communications. As part of this approach, the project planned to implement a fraud and complaints hotline and reporting system to enhance health worker accountability. Using a cluster model strategy, the project planned to first prioritize building capacity at a high-performing facility in a HZ, and once strengthened, use that health structure to provide support and outreach to facilities in the same HZ. The project aimed to strengthen other facilities located in more remote locations over the course of the project.

Community-based health activities were considered critical to increasing the use of facility services and improving the provision of essential health services, especially in remote locations. Interventions designed to strengthen community-based health services included recruitment of new community health workers (CHWs), especially women; training CHWs on health promotion (with a focus on WASH) and integrated community case management (iCCM); and training facility-based health workers on community outreach and the provision of health services at the community level. Interventions to strengthen referrals from community platforms and health centers (HCs) to referral hospitals were also planned. Building collaboration with government health structures, the United States Government, and other donors by supporting and actively participating in central-level meetings during which learning experiences, needs, and priorities were jointly identified and discussed, and policy influenced were also viewed as important.

Objective 3: Increase the Adoption of Healthy Behaviors, including the Use of Health Services in Target Health Zones

The planned interventions related to Objective 3 were meant to increase the adoption of healthy behaviors and the use of health services in targeted provinces. The strategy aimed to raise community awareness and knowledge of health services and address barriers to optimal health-seeking, and to strengthen community engagement and social support to enable healthy behaviors. Specific interventions were to include a "healthy

family" campaign composed of a multipronged educational program involving a family drama series focusing on common health problems and issues related to accessing facility and community-based health services, the care received, and satisfaction derived. Storylines disseminated through radio and text messaging were to highlight sociocultural barriers that inhibit access to services and the practice of healthy behaviors, and ways that these barriers can be overcome. Radio listening sessions organized to facilitate community discussions and reactions to scenarios presented during the drama series were planned at the local level. The messages conveyed through the drama series were to be complemented by interpersonal communication carried out by CHWs and CODESAs, and supported by women's organizations and other community-based groups through mobilization events. Open houses were to be held to highlight improvements in health facilities and encourage use.

The Champion Community model was planned to prioritize health areas (HAs) and target audiences, and to develop workplans and monitor activities in the targeted areas. Mini-campaigns were to focus on addressing health problems according to specific and immediate needs. Efforts to share lessons learned, harmonize strategies, and improve approaches by collaborating and coordinating with other groups involved in SBC were to include the following: key government institutions working on communications; government officials, implementing agencies, and others participating in coordination meetings (clusters, *Médecin Chef de Zone* [HZ head physician], head nurse) at the central, provincial, and zonal levels; and USAID staff and partners.

The project aimed to share SBC activity results with international audiences during academic conferences and through peer-reviewed, scientific manuscripts. At the local level, coordination of SBC approaches was planned with HZ offices, CODESAs, and *cellules d'action communautaires* (CACs; Community Action Committees, which are community-level organizations that engage in health communication), with assistance to HZs during the development of their operational action plans to ensure the overall goal of scalability of sound and effective messaging and activities that align with and contribute to the achievement of agreed on health goals.

Methods

Quantitative Component

Survey Design

The provincial health office survey and the HZ office survey were identical instruments that contained questions on basic information, staffing, infrastructure, sources and uses of funding, community funding initiatives, support from USAID IHP, management and supervision, coordination and collaboration, capacity strengthening, and the health management information system.

The health facility survey, which was administered to hospitals and HCs, was comprised of six modules: management, services, finance, infrastructure, medications, and a medical record review.

At each surveyed health facility, a health worker module was administered. At hospitals, this survey was given to a maximum of one physician, one nurse, and one midwife who were present on the day of the survey and who were general practitioners who provided antenatal care (ANC), delivery care, postnatal care, or pediatric services. They were selected randomly, with replacement, from the duty roster. At HCs, all physicians, nurses, and midwives who were present on the day of the survey and who provided clinical services were invited to participate. The health worker survey contained questions about basic information, training, management and supervision, provider income, provider satisfaction, and provider motivation.

Health workers also responded to clinical vignettes. Each surveyed health worker was asked whether they regularly provided child health services, FP services, and adult health services. They were then given the corresponding vignette(s), which guided them through a hypothetical patient and collected data on how they would approach the case at each stop of the visit. Table 1.1 shows the vignettes that were administered at each round of data collection.

Table 1.1. Clinical vignettes by topic and survey round

	2019	2021	2024
Child health	Dysentery*	Pneumonia	Dysentery*
FP	New user*	New user*	New user*
Adult health	-	COVID-19	-

*Indicates that the same vignette was used in multiple survey rounds.

The CODESA survey asked questions about the CODESA representative, CODESA composition and functioning, compensation, perceptions of the health facility, support and coaching, motivation, and job satisfaction.

The *relais communautaires* (RECOs, i.e., CHWs) survey asked about basic information, incentives and compensation, RECO composition and functioning, training, coaching, motivation, and job satisfaction.

Data Collection

The analyses presented in this report used three waves of data collected from provincial health offices, HZ offices, hospitals, and HCs. The baseline survey was conducted in six provinces (Sud Kivu, Tanganyika, Kasai Oriental, Sankuru, Haut Katanga, and Lualaba), and the midline survey was conducted in these provinces and the remaining three provinces (Kasai Central, Lomami, and Haut Lomami). For the midline and endline

surveys, we added modules for CODESA (i.e., community health committee) members, and *relais communautaires* (i.e., CHWs).

In each selected province, data collectors attempted to survey all existing HZ offices. In each HZ, three HCs/posts were randomly selected. Once the facilities were selected, data collectors called via phone or visited the facility and spoke with the facility head. If the facility head agreed to participate, data collectors conducted surveys with that facility and its associated health workers. If the facility did not agree to participate, the next closest health facility in the HZ was invited to participate. If a health worker refused, they were replaced if there was another eligible health worker present. In addition, at each HC, we attempted to survey the highest-ranking CODESA member available (typically, the CODESA president or vice president), and two randomly selected CHWs.

For the six provinces that were included in the baseline evaluation, we attempted to survey the same facilities during all three waves of data collection. For the three additional provinces that were added as part of the midline evaluation, we attempted to survey the same facilities in the endline evaluation. The Kinshasa School of Public Health administered the surveys.

Analysis of Change Over Time in USAID IHP-Supported Areas

The analyses that showed change over time from baseline to endline are based on a restricted sample of facilities that were surveyed in each of these waves, whereas the analyses that showed change over time from midline to endline are based on a restricted sample of facilities that were surveyed in these waves. Because some facilities surveyed at baseline could not be revisited at midline, the results presented in this report may differ slightly from the results in the baseline report. This is also the case for the midline survey because some facilities included in this wave could not be revisited at endline. The values for key indicators were tabulated for each wave individually, and the absolute and percentage point changes between 2019 and 2024 were calculated, and between 2019 and 2024 were calculated. Unadjusted tests of statistical significance (chi-square tests and Fischer's exact tests) were done. Results were stratified by province. For composite indicators (e.g., offering the minimum package of preventive services), findings were also disaggregated by the indicators comprising them (ANC, FP services, etc.) overall.

It should be noted that questionnaires were divided into modules so that multiple data collectors could work at the same facility in tandem. Each survey module was administered separately; therefore, in a very limited number of cases, a facility may be missing an individual module. This means that the n values may differ slightly throughout the analyses.

Cross-Sectional Analyses in USAID IHP-Supported Areas

As stated previously, in the midline and endline surveys, modules for CODESA members and CHWs were added, and the survey area was expanded to include the three additional provinces (Kasai Central, Lomami, and Haut Lomami) that were not surveyed at baseline. Select indicators related to USAID IHP's community approach are presented for 2021 only and are disaggregated by all nine provinces supported.

Qualitative Component

Instrument Design

The qualitative data collected examined the design and implementation of USAID IHP activities, changes observed to date, and the impact of contextual factors on the program and the health system generally.

Data Collection

A team of researchers collected qualitative data between March and August 2024 at the central level and in two USAID IHP target provinces (Sud Kivu and Kasai Oriental) where the midline qualitative evaluation was also conducted. The research team was comprised of an international qualitative researcher, two researchers from the University of Kinshasa, and one local researcher and data collector based in each of the target provinces. The team consisted of four women and three men. The team employed a mix of methods involving key informant and in-depth interviews, focus group discussions (FGDs), and observations.

Researchers administered key informant interviews to a range of health professionals from the central to the zonal levels in Sud Kivu and Kasai Oriental, with key informants typically interviewed on more than one occasion. At the central level, key informants included USAID IHP personnel, USAID staff, and MOH officials.

In Sud Kivu, the team collected data in March and April 2024. Key informants included two USAID IHP representatives, two staff in the *Division Provinciale de Santé (*DPS, Provincial Health District) office, a provincial inspection office staff member, three staff members in the Miti Murhesa HZ, three staff members in the Walungu HZ, and a representative of a collaborating nongovernmental organization (NGO) that was overseeing implementation of the Ukraine Funds. All key informants interviewed were male.

In Sud Kivu, the evaluation was carried out in a higher performing and a lower performing HZ according to the child health indicators, including HC attendance for major child illnesses and vaccination coverage. We selected HZs where data from each of these indicators were clearly above or below the provincial averages. In each HZ, we targeted a higher performing and lower performing HA using the same approach. We focused on these two indicators, identifying HZs where each indicator results were clearly below or above the provincial averages. In each HA, we conducted in-depth interviews with a head nurse (*infirmière titulaire* or IT) and a RECO, and in three of four of the HAs, we carried out in-depth interviews with senior CODESA members (Table 1.2). We also administered in-depth interviews in the reference hospitals with clinicians and hospital administrators. Observations of four facility infrastructures, including the equipment and medications available, were also conducted.

FGDs were held with 6–12 mothers and grandmothers of children under five years of age in each of the four HAs (four HAs in total) included in the evaluation. Discussions mainly focused on child health services and care seeking for sick children.

In Kasai Oriental, data collection occurred in April and May 2024. Key informants included five representatives from USAID IHP, three representatives from the DPS, one representative from the provincial inspection office, a staff member of an NGO collaborating with USAID IHP, and the chief medical officers of the two targeted HZs. Three of the 12 key informants were women.

In Kasai Oriental, the evaluation was carried out in a higher performing and a lower performing HZ according to child health indicators, including HC attendance for major child illnesses and immunization, and in each HZ, we targeted a higher performing and lower performing HA. In each HA, in-depth interviews were conducted with the head nurse, a CODESA member, and a RECO. Interviews were also administered with RECOs in charge of iCCM posts. In addition, researchers conducted in-depth interviews at the *Hôpital Général de Référence* (HGR, General Reference Hospital) with a hospital administrator and clinician. Observations of facility infrastructures, equipment, and medications constituted another component of the evaluation.

FGDs were held with 6–12 guardians of children under five years of age in each of the four HAs to assess

perceptions and use of child health services.

Table **1.2. Number of interviews carried out by research method during the endline qualitative evaluation**

Research method	Number			
	Sud Kivu	Kasai Oriental	National	Total
Key informants	12	14	5	31
In-depth interview informants	11	14	-	25
Facility observations	6	6	-	12
Focus group discussions	4	4	-	8

Data Analysis

Data from key informant and in-depth interviews were audio recorded, translated from the local language into French when needed, and transcribed in French. Based on reviews of data transcripts, research assistants and the lead researcher worked together to develop a coding system. Coding categories were derived from the initial research themes and questions, as well as from key concepts that emerged during data collection. Coding of the interview transcripts was done using ATLAS.ti, a text-organizing software. Data collected from the FGDs and observations were coded in a Word document. FGD moderators followed the guide closely, and as a result, it was easy to compile the data according to key concepts/topic areas. Therefore, the use of a text-organizing software was not necessary.

Content analysis was used to identify trends of concepts in and across individual codes derived from the different research methods. The combination of data, environmental, and methodological triangulation facilitated data analysis across the different sites and methods, and across and between key informants and in-depth interview respondents.

Results: Funding and Implementation of USAID IHP

This section presents findings on the implementation of USAID IHP, drawing from key informant interviews and an analysis of USAID IHP's annual reports. It covers funding changes, factors that impacted implementation, key programmatic approaches, challenges, successes, and an overview of complementary health systems strengthening projects in the USAID IHP-targeted provinces. Due to the small sample size and unique roles among the national-level informants, throughout this section, quotations are not attributed to individuals to protect anonymity.

Factors That Impacted the Implementation of USAID IHP

Funding Levels and Budget Cuts

Table 1.3. USAID IHP's cumulative budget and expenditures, including supplementary funds, by program

Program Area	Year 1 Oct. 2018 – Sep. 2019	Year 2 Oct. 2019 – Sep. 2020	Year 3 Oct. 2020 – Sep. 2021	Year 4 Oct. 2021 – Sep. 2022	Year 5 Oct. 2022 – Sep. 2023	Year 6 Oct. 2023 – Sep. 2024	Year 7 (Estimated amounts)	Total
TB	$1,998,085	$5,542,747	$3,571,099	$6,017,795	$1,068,205	$2,570,312	$2,132,683	$22,900,926
Malaria	$1,938,931	$3,847,074	$8,112,864	$8,486,112	$3,589,813	$10,053,886	$7,827,591	$43,856,271
MNCH	$6,680,943	$10,530,325	$26,427,502	$25,581,901	$8,529,741	$15,993,204	$12,169,291	$105,912,907
FP/RH	$4,018,763	$3,821,485	$12,533,617	$10,357,280	$4,299,220	$7,811,646	$7,089,273	$49,931,284
WASH	$2,208,580	$1,509,275	$2,185,449	$693,363	$23,333	$0	$0	$6,620,000
Nutrition	$1,198,888	$2,439,747	$4,698,299	$4,794,977	$3,678,013	$7,167,012	$2,915,952	$26,892,887
COVID	$0	$0	$0	$271,147	$1,542,140	$2,386,714	$2,286,000	$6,486,000
Ukraine Supplemental Funding	$0	$0	$0	$0	$64,666	$6,547,959	$3,387,375	$10,000,000
Total Estimated Cost-Plus Fixed Fee	$18,044,190	$27,690,653	$57,528,829	$56,202,575	$22,795,130	$52,530,733	$37,808,164	$272,600,275

According to the USAID IHP annual reports, the program faced significant budget cuts starting in 2022. These reductions necessitated a descoping exercise, leading to the discontinuation of WASH activities, staff reductions, and the closure of offices in four provinces. The program shifted its focus from direct implementation of activities to providing technical assistance to the MOH. The program's Kinshasa central office assumed many responsibilities that were previously managed by staff in Washington.

Key informant interviews conducted for the endline evaluation revealed that budget constraints also affected program flexibility and responsiveness, especially in 2022 when the program did not receive new funds. Informants noted that these financial limitations required strategic adjustments, including reducing program scope and prioritizing high-impact interventions.

It should also be noted that the program received Ukraine supplementary funds and COVID-19 response funds

in addition to program-specific funds.

- **Ukraine Supplementary Funding:** These funds, which were received starting in 2023, were used to support malnutrition interventions in four high-need provinces—Kasai Oriental, Kasai Central, South Kivu, and Lomami—by promoting community agriculture, small animal raising, and food transformation activities targeted at women.
- **COVID-19 Response:** In 2021, USAID IHP was allocated $4 million to integrate COVID-19 vaccination in routine health services and raise community awareness on COVID-19 prevention. Key informant interviews highlighted the challenges posed by the pandemic, such as disruptions in communication with provincial collaborators, delays in supply delivery, and a reduction in monitoring activities.

In addition, according to the annual reports, the program mobilized funds from mining royalties in Lualaba and Haut Katanga provinces, resulting in a $20 million investment in health infrastructure. This initiative, which was mentioned and highlighted by key informants, was seen as a major success in bolstering the health systems in these areas.

According to the key respondents interviewed, the program faced several challenges.

- Trafficking in persons (TIP) sanctions: At the beginning of the project, USAID announced that USAID IHP would not receive a waiver to secure USAID IHP funding due to the DRC's status as a Tier 3 country in the U.S. Government Trafficking in Person report. This caused USAID IHP to rapidly shift its focus from government to nongovernment actors. The program's provincial staff started to identify faith-based organizations in the health sector that could begin working with USAID IHP starting in October 2019. However, more long-term planning was needed to identify and implement activities in more rural areas. In May 2019, USAID approved the extension of USAID IHP's existing workplan through June 2019. However, in mid-June, USAID IHP received news that new funding would not be affected by TIP sanctions, and by July 1, 2019, the program received clearance and was no longer required to reorient technical assistance activities (USAID IHP: fiscal year 2019 [FY2019] Annual Report, pp. 5-6).
- This abrupt redirection of activities affected the program's planned acceleration of activities during the fourth quarter of FY2019, especially the implementation of activities that involved the MOH.
- Government engagement: A recurrent theme from key informant interviews was the lack of ownership by health officials for routine activities under the MOH mandate, and difficulties in maintaining adequate drug stocks. Informants frequently cited these issues as barriers to the sustainability of program interventions.
- COVID-19 pandemic: The COVID-19 pandemic that began in 2020 had significant impacts on both the DRC's health systems and the implementation of USAID IHP. This topic was investigated as part of the 2021 midline evaluation of USAID IHP. The DRC government attempted to implement a range of control and preventive measures to mitigate the spread of the disease. However, according to key informants interviewed for the evaluation, economic and social factors affected the willingness of the general population to subscribe to mitigation measures, with prevailing beliefs and skepticism about the virus affecting vaccine acceptance.
- The pandemic led to disruptions in the implementation of USAID IHP. There was a decrease in communication with collaborators, especially in isolated provinces, leading to miscommunication. In addition, there were reductions in monitoring visits and the implementation of the program's technical assistance activities. Delays in the delivery of supplies and medications also occurred.
- Nurses' strike: The nurses' strike that took place in 2021 led to disruptions. Initially the strike was

composed of non-medical nursing staff but soon expanded to include nurses and administrators. The provinces most affected by the strike were Tanganyika, Haut Katanga, Sankuru, Lomami, and Sud Kivu. Health facilities were temporarily closed due to the lack of available staff in some areas. However, in Lualaba, Haut Katanga, and Kasai Central, provincial authorities were able to work with providers to continue activities, in collaboration with other partners (USAID IHP's FY2021 Annual Report, pp. 5-6).

- The strike significantly impacted USAID IHP's ability to implement planned activities in 2021, with only 56 percent of scheduled activities being completed. Nearly all program areas experienced reductions in the number of curative, preventative, and community-based services provided. Moreover, data were not fully reported at the health facility and HZ office levels, which affected the timeliness of reporting to the District Health Information Software, version 2 (DHIS2) and the supply chain in terms of managing stocks.
- According to USAID IHP's annual reports, USAID IHP worked with the provinces most affected by the strike, and identified, adjusted, and planned activities according to priorities. These steps were reported to have helped ensure provincial ownership and reaffirm the provinces' commitment to the implementation of activities to prevent administrative blockages.

- Staff turnover: The implementation of USAID IHP faced significant challenges due to the high turnover of senior-level staff. In 2020, the Director of Operations, Senior Procurement Manager, and Chief of Party left the project. In 2021, an internal investigation led to the dismissal of the Deputy Chief of Party, two Senior and Regional Coordinators, four Provincial Directors, and six subcontractor staff. In 2022, budget cuts resulted in 58 staff layoffs, and key positions, such as the Project Manager, Country Operations Manager, Security Manager, and Regional Advisor at the headquarters level, were vacated, although all these roles were subsequently filled.

Description of Implementation of USAID IHP

Objective 1: Strengthen Health Systems, Governance, and Leadership at Provincial, Health Zone, and Facility Levels in Target Health Zones

Key Activities and Outcomes

According to the annual reports, USAID IHP concentrated on strengthening health systems governance by supporting the development of annual operational plans and conducting PICAL assessments across all nine DPS and 179 HZs. These efforts aimed to enhance strategic planning and communication among health professionals, enabling better management and coordination in the health system. Key informants noted that the operational plans developed in USAID IHP target provinces were significantly more organized and clearly defined compared with those in other provinces, illustrating the positive impact of USAID IHP's support.

The program also introduced critical accountability mechanisms, including a fraud and abuse hotline, which was documented in the annual reports as having received numerous reports that led to investigations and proposed sanctions. Key informants described the hotline as one of the most impactful activities, significantly improving transparency and exerting pressure on health personnel to comply with government norms designed to prevent corruption. Another significant strategy was the implementation of the community scorecard, which was used as a participatory tool to engage communities in assessing and improving health service delivery. This approach empowered communities to voice their concerns and hold health providers accountable, fostering greater transparency and responsiveness in the health system.

Challenges

Cross-Cutting Challenges

- High staff turnover: A pervasive issue noted across all strategies was the high turnover of health personnel, which was often driven by political factors. This turnover disrupted the continuity of program activities and undermined the effectiveness of governance initiatives.
- Political interference: Political interference in the management of health personnel and decision-making processes was a major cross-cutting challenge. Informants frequently cited this as a barrier that affected leadership stability and hindered the enforcement of accountability measures across various governance strategies.

Strategy-Specific Challenges

- Development of operational plans and PICAL assessments: The implementation of these assessments faced challenges related to varying levels of engagement from provincial health officials. In some areas, the lack of commitment from local leadership led to inconsistent application of the assessments and hindered the ability to standardize governance improvements across all HZs.
- Fraud and abuse hotline: Although the hotline was effective in receiving reports, informants noted that the follow-up on reported cases was often inadequate due to limited resources and political pressures. This challenge specifically impacted the strategy's ability to effectively sanction misconduct and enforce accountability.
- Community scorecard: The community scorecard strategy encountered specific challenges, including resistance from some health providers who were unaccustomed to community scrutiny and accountability. There were also logistical difficulties in facilitating community participation consistently, especially in remote areas, which affected the full implementation and impact of the scorecard process.

Objective 2: Increase Access to Quality, Integrated Health Services in Target Health Zones

Key Activities and Outcomes

According to the annual reports, USAID IHP aimed to increase access to quality integrated health services through a multifaceted approach, covering key programmatic areas, such as malaria, TB, maternal and child health (MCH), nutrition, FP, and the improvement of referral systems. These programmatic areas were targeted across all nine provinces, with a focus on enhancing the delivery and quality of services in each specific area.

- **Malaria and TB:** USAID IHP expanded iCCM sites and provided technical assistance to support the national malaria strategy. The program supported TB interventions by working with community-based organizations for case screening and the transport of sputum samples. According to key informants, these efforts led to increased detection rates for both malaria and TB. However, they noted that challenges persisted, especially access to remote areas, and the limited oversight and involvement of the government in sustaining these efforts.
- **MCH:** The program introduced clinical mentoring and established centers of excellence to improve the quality of delivery and newborn care. The annual reports highlighted that these centers provided advanced training for health workers on lifesaving practices during delivery and the postpartum period. Key informants confirmed that these initiatives significantly improved service quality and increased the use of maternal health services, especially in underserved areas.

- **Nutrition:** USAID IHP's nutrition strategy focused on community-based infant and young child feeding (IYCF) groups. These groups conducted culinary demonstrations using locally available foods to promote healthy feeding practices. According to the annual reports, this approach was sustainable and community-driven, although it faced challenges in achieving broad coverage and in securing active engagement from government stakeholders. Key informants noted that although the strategy was effective in raising awareness, scaling it up across all target areas proved difficult due to limited resources and varying levels of community participation.
- **FP:** The program supported FP initiatives by training health workers and distributing commodities, such as contraceptives. These efforts were detailed in the annual reports as crucial for increasing access to FP services across the provinces. However, key informants pointed out that motivating community-based distributors, who operated as volunteers, remained a significant hurdle. Inconsistent volunteer engagement and support were cited as ongoing challenges to the full implementation of FP services.
- **Referral systems:** Improving the referral system was another critical component of USAID IHP's strategy. The program provided referral forms and conducted training for health workers on proper referral protocols to facilitate patient transfers from primary to higher-level facilities. Despite these efforts, key informants reported that the referral system continued to face significant barriers. Low acceptance of referrals was common, primarily due to concerns about the costs associated with referrals and the perceived quality of care at referral facilities. These challenges underscored the need for additional support and reinforcement of the referral processes to improve patient outcomes.

Challenges

Challenges

Cross-Cutting Challenges

- Resource limitations: Across all programmatic areas, limited resources and funding constraints were frequently cited as cross-cutting challenges. These limitations affected the scale and consistency of service delivery improvements.
- Engagement of health workers and volunteers: Another cross-cutting challenge was the inconsistent engagement of health workers and volunteers, which impacted the effectiveness of training and service provision across multiple program areas.

Programmatic Area-Specific Challenges

- **Malaria and TB:** Access to remote areas was a specific challenge, compounded by logistical difficulties in maintaining the supply chain for essential medications and diagnostic tools.
- **MCH:** Key informants noted challenges in maintaining the quality of mentoring and training due to high turnover among health workers, which disrupted the continuity of capacity-building efforts.
- **Nutrition:** Achieving broad community participation in nutrition initiatives was difficult, especially in areas with limited government support or in communities resistant to behavior change.
- **FP:** The reliance on volunteers for distribution posed significant challenges because their motivation and availability varied widely, affecting service consistency and reach.
- **Referral systems:** The primary challenge was overcoming patient resistance to referrals, driven by fears of high costs and inadequate care at referral facilities, which highlighted the need for more patient education and support.

Objective 3: Increase the Adoption of Healthy Behaviors, including the Use of Health Services in Target Health Zones

Key Activities and Outcomes

USAID IHP worked to revive community engagement structures, such as CODESA and CAC committees, scaling up VIVA interventions (an innovative social and behavior change campaign) across the nine provinces. According to the annual reports, these efforts aimed to enhance community participation in health management. Key informants highlighted several success stories, such as community-led initiatives to improve health facility infrastructure and service delivery, demonstrating the value of active community involvement in health systems strengthening.

To improve patient-provider interactions, USAID IHP implemented training programs designed to enhance health worker interpersonal skills, especially empathy. The annual reports noted that these training sessions were conducted across a significant number of health facilities, with oversight provided by central MOH personnel. Key informants emphasized the importance of these efforts in fostering better communication and trust between health workers and community members, although they acknowledged that high health worker turnover continued to challenge the sustainability of these improvements.

SBC campaigns, supported by local and mass media, were also a critical component of USAID IHP's strategy to increase the adoption of healthy behaviors and the use of health services. Key informants reported that these campaigns were instrumental in raising awareness and encouraging community members to engage more actively with available health services.

Other USAID Implementing Partners Working in USAID IHP Project Areas

There were also other large health systems strengthening projects that were implemented with support from other donors during the USAID IHP period. They included many projects supported by USAID and other projects financed at least in part by other donors and international health partners. The projects are listed in a table in Appendix 2.

Transition Strategy

USAID IHP developed a transition strategy with the aim of ensuring sustainability and ownership of its interventions by local entities as the project phased out. Key components included strengthening governance and leadership in health systems; expanding approaches, such as the PICAL tool and community scorecards to additional provinces; and enhancing accountability measures, such as the health hotline. The strategy emphasized collaboration with local partners and stakeholders, including government agencies and other international organizations, to maintain the program's achievements. In addition, the strategy indicated that USAID planned to extend support for six months post-project to facilitate the transition, with a comprehensive communications plan to share knowledge products and results with relevant stakeholders.

Quantitative Results

Sample Sizes, By Respondent Types

The number of responding facilities and individuals is shown in Table 2.1a, and the reported number of clinical staff by facility type, gender, cadre, and year is shown in Table 2.1b. It should be noted that sample sizes in the results tables may vary depending on the number of facilities or individuals who responded to specific survey modules and/or survey questions. In total, six provincial health offices, 103 HZ offices, 111 hospitals, and 297 hospitals were surveyed across all three waves. Among clinical staff, there were substantial differences in gender distribution within cadres. The largest fluctuations by gender were among midwives, with the percentage of males increasing, and among maintenance techs, with the percentage of females increasing.

Table 2.1a Responding health offices, facilities, CODESAs, and *relais communautaire* (CHW), by survey round

Respondent Type	2019	2021*	2024*	Matched 2019–2024	2024 Full Sample
Provincial Health Office	6	6	6	6	9
Health Zone Office	106	175	178	103	178
Hospital	117	148	178	111	178
Health Center	341	549	539	297	539
Health Worker	1075	1024	1143	N/A**	1995
CODESA	N/A	444	444	N/A	460
CHW	N/A	987	1072	N/A	1096

*Limited to the six provinces surveyed in 2019: Sud Kivu, Tanganyika, Haut Katanga, Lualaba, Sankuru, and Kasai Oriental.
** Matched health worker analyses were limited to health workers at facilities that we surveyed in 2019, 2021, and 2024. Individual health workers cannot be tracked across survey rounds.

Table 2.1b. Reported number of clinical staff by facility type, gender, cadre, and year

		2019 to 2024 panel			
		2019 %	2021 %	2024 %	PP diff (2019 vs 2024)
Hospital					
Nurses A1/A2	Female	52.3	53.9	51.4	-0.8
	Male	47.7	46.0	48.1	0.3
Midwives	Female	95.5	92.0	93.7	-1.8
	Male	4.5	8.0	6.3	1.8
Lab Techs	Female	36.8	34.7	37.4	0.7
	Male	63.7	65.3	63.0	-0.7
Maintenance Tech	Female	34.3	36.8	43.0	8.7
	Male	65.7	63.2	57.0	-8.7
Health Center					
Nurses A1/A2	Female	38.3	39.8	40.2	1.9
	Male	61.3	60.2	59.9	-1.4

Midwives	Female	98.3	85.1	93.4	-4.9
	Male	1.7	14.9	3.3	1.6
Lab Techs	Female	37.5	43.8	39.4	1.9
	Male	62.5	56.3	60.6	-1.9
Maintenance Tech	Female	73.3	64.4	58.8	-14.6
	Male	26.7	35.6	42.5	15.8
			2021 to 2024 panel		
			2021	2024	
			%	%	PP diff (2021 vs 2024)
Hospital					
Nurses A1/A2	Female		37.7	41.2	3.5
	Male		62.3	58.7	-3.6
Midwives	Female		94.7	80.9	-13.9
	Male		5.3	19.1	13.9
Lab Techs	Female		20.0	18.4	-1.6
	Male		80.0	81.6	1.6
Maintenance Tech	Female		46.7	35.7	-11.0
	Male		53.3	64.3	11.0
Health Center					
Nurses A1/A2	Female		40.8	38.0	-2.8
	Male		58.9	61.8	2.9
Midwives	Female		82.9	91.5	8.6
	Male		17.1	8.5	-8.6
Lab Techs	Female		21.9	40.0	18.1
	Male		76.6	60.0	-16.6
Maintenance Tech	Female		38.6	58.5	19.9
	Male		61.4	41.5	-19.9

Note: A1 nurses hold a higher diploma in nursing, typically obtained after completing three years of post-secondary education. This level is equivalent to a bachelor's degree in nursing. A2 nurses usually have completed secondary-level education and a subsequent two-year diploma or certificate in nursing.

PP=percentage point

Leadership and Governance

Health Zone Office Representation for Surveys/Interviews

For the HZ offices, data collectors were instructed to administer the survey to the highest-ranking official present. In 2019, nearly 60 percent of respondents self-reported as the head of the HZ office, whereas only 53.4 percent of respondents reported this at the time of the 2024 survey (Table 2.2a). This decrease was not statistically significant overall. However, Sud Kivu experienced a statistically significant decrease of 28 percentage points (PPs) between 2019 and 2024, with much of the decrease occurring between 2021 and 2024.

By contrast, for the three provinces surveyed in 2021 and 2024 only, the percentage of respondents self-reported as head of the HZ office increased from 44.6 percent to 76.8 percent, a statistically significant increase (Table 2.2b).

Table 2.2a. Health zone office head is survey respondent, by province and survey round

		Matched panel (n = 103)				
		2019%	2021%	2024%	PP diff (2019 vs 2024)	p-value (2019 vs 2024)
Overall (6 provinces)		59.2	46.6	53.4	-5.8	0.44
Eastern Congo						
	Sud Kivu	56.0	48.0	28.0	-28.0	0.04**
	Tanganyika	100.0	77.8	66.7	-33.3	0.21
Katanga						
	Haut Katanga	63.0	33.3	55.6	-7.4	0.58
	Lualaba	45.5	45.5	63.6	18.2	0.41
Kasai						
	Sankuru	66.7	66.7	66.7	0.0	1.00
	Kasai Oriental	37.5	31.3	62.5	25.0	0.16

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Table 2.2b. Health zone office head is survey respondent, by province and survey round

		Matched panel (n = 56)			
		2021%	2024%	PP diff (2021 vs 2024)	p-value (2021 vs 2024)
Overall (3 provinces)		44.6	76.8	32.2	<0.01***
Katanga					
	Haut Lomami	62.5	75.0	12.5	0.45
Kasai					
	Kasai Central	30.8	65.4	34.6	0.01***
	Lomami	50.0	100.0	50.0	0.01***

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

In 2019, just over half (51.5%) of interviewees reported their position as chief medical officer, dropping by nearly one PP to 50.5 percent at the time of the 2024 survey (Table 2.3a). However, in Tanganyika, the number of respondents reporting their position as the chief medical officer decreased by more than 55 PPs, a significant decrease, whereas Kasai Oriental observed a statistically significant increase of 31.3 PPs (Table 2.3a). In the provinces surveyed twice, there was a statistically significant increase of 37.5 PPs in respondents reporting their position as the chief medical officer. Both Kasai Central and Lomami doubled their 2019 indicators, resulting in 93 percent of the respondents in Lomami reporting being chief medical officers (Table 2.3b). At the time of the 2024 survey, Sud Kivu was the province where the highest-ranking officials were least likely to be interviewed based on percentages (Table 2.3a).

Table 2.3a. Health zone chief medical officer is survey respondent, by province and survey round

		Matched panel (n = 103)				
		2019%	2021%	2024%	PP diff (2019 vs 2024)	p-value (2019 vs 2024)
Overall (6 provinces)		51.5	46.6	50.5	-1.0	0.94
Eastern Congo						
	Sud Kivu	36.0	44.0	32.0	-4.0	0.77
	Tanganyika	100.0	77.8	44.4	-55.6	0.03**
Katanga						
	Haut Katanga	51.9	33.3	48.2	-3.7	0.79
	Lualaba	54.6	54.6	63.6	9.1	0.68
Kasai						
	Sankuru	66.7	66.7	66.7	0.0	1.00
	Kasai Oriental	31.3	31.3	62.5	31.3	0.08*

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Table 2.3b. Health zone chief medical officer is survey respondent, by province and survey round

		Matched panel (n = 56)			
		2021%	2024%	PP diff (2021 vs 2024)	p-value (2021 vs 2024)
Overall (3 provinces)		33.9	71.4	37.5	<0.01***
Katanga					
	Haut Lomami	56.3	75.0	18.8	0.26
Kasai					
	Kasai Central	19.2	57.7	38.5	<0.01***
	Lomami	35.7	92.9	57.1	<0.01***

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Capacity to Plan, Implement, and Monitor Services

Electricity enables efficient work and regular communication. Overall, 55.4 percent of HZ offices in the six-province panel had a source of electricity in 2024, up from 43.7 percent in 2019 (Table 2.4a). HZs in Tanganyika had the highest percentage of offices with electricity in 2024 (77.8%) and HZs in Kasai Oriental had the lowest percentage in 2024 (12.5%). Overall, there was a statistically significant increase in electricity availability across all six provinces. Both Sankuru and Tanganyika reported increases in electricity availability of 46.7 and 44.4 PPs, respectively. There were no significant differences in the percentage of HZs with availability of electricity in the three provinces surveyed in 2021 and 2024 (Table 2.4b).

Moreover, there was a slight decrease in the number/percentage of HZ offices with functioning electricity at the time of the survey between 2019 to 2024 (Table 2.5a); however, there were no differences in offices reporting eight hours of electricity (Table 2.6a). Only Tanganyika experienced a significant change in electricity availability, increasing from 50 percent to 100 percent of HZ offices between 2019 and 2024 (Table

2.6a). Considering just the 2024 data, a cross section of 56.7 percent (101 of 178 offices) surveyed had access to functional electricity.

Table 2.4a. Health zone offices with any source of electricity, by province and survey round

		Matched panel (n = 103)				
		2019%	2021%	2024%	PP diff (2019 vs 2024)	p-value (2019 vs 2024)
Overall (6 provinces)		43.7	50.5	55.4	11.6	0.08*
Eastern Congo						
	Sud Kivu	52.0	56.0	56.0	4.0	0.78
	Tanganyika	33.3	33.3	77.8	44.4	0.15
Katanga						
	Haut Katanga	74.1	81.5	74.1	0.00	1.00
	Lualaba	45.5	54.6	36.4	-9.1	1.00
Kasai						
	Sankuru	20.0	33.3	66.7	46.7	0.01***
	Kasai Oriental	6.3	12.5	12.5	6.3	1.00

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Table 2.4b. Health zone offices with any source of electricity, by province and survey round

		Matched panel (n = 56)			
		2021%	2024%	PP diff (2021 vs 2024)	p-value (2021 vs 2024)
Overall (3 provinces)		59.0	59.0	0.0	1.00
Katanga					
	Haut Lomami	75.0	62.5	-12.5	0.45
Kasai					
	Kasai Central	69.2	69.3	0.0	1.00
	Lomami	21.4	35.7	14.3	0.68

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Table 2.5a. Health zone offices with functioning electricity on the day of the survey, by province and survey round

		Matched panel (n = 35)				
		2019%	2021%	2024%	PP diff (2019 vs 2024)	p-value (2019 vs 2024)
Overall (6 provinces)		88.6	82.9	77.1	-11.4	0.59
Eastern Congo						
	Sud Kivu	80.0	80.0	80.0	0.0	1.00
	Tanganyika	50.0	50.0	100.0	50.0	0.07*

		Matched panel (n = 35)				
		2019%	2021%	2024%	PP diff (2019 vs 2024)	p-value (2019 vs 2024)
Katanga						
	Haut Katanga	94.1	88.2	70.6	-23.5	0.24
	Lualaba	100.0	66.7	66.7	-33.3	0.44
Kasai						
	Sankuru	100.0	100.0	100.0	0.00	1.00
	Kasai Oriental	100.0	100.0	100.0	0.00	1.00

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Table 2.5b. Health zone offices with functioning electricity on the day of the survey, by province and survey round

		Matched panel (n = 22)			
		2021%	2024%	PP diff (2021 vs 2024)	p-value (2021 vs 2024)
Overall (3 provinces)		77.3	90.9	13.6	0.28
Katanga					
	Haut Lomami	71.4	100.0	28.6	1.00
Kasai					
	Kasai Central	78.6	85.7	7.1	0.66
	Lomami	100.0	100.0	0.0	1.00

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Table 2.6a. Health zone offices with eight hours of electricity among those offices with functional electricity, by province and survey round

		Matched panel (n = 35)				
		2019%	2021%	2024%	PP diff (2019 vs 2024)	p-value (2019 vs 2024)
Overall (6 provinces)		57.1	42.9	57.1	0.0	0.62
Eastern Congo						
	Sud Kivu	60.0	40.0	60.0	0.0	0.58
	Tanganyika	100.0	0.0	100.0	0.0	0.30
Katanga						
	Haut Katanga	47.1	41.2	47.1	0.0	0.53
	Lualaba	100.0	66.7	66.7	-33.3	0.44
Kasai						
	Sankuru	0.0	50.0	50.0	50.0	0.07*
	Kasai Oriental	100.0	100.0	100.0	0.0	1.00

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Table 2.6b. Health zone offices with eight hours of electricity among those offices with functional electricity, by province and survey round

		Matched panel (n = 22)			
		2021%	2024%	PP diff (2021 vs 2024)	p-value (2021 vs 2024)
Overall (3 provinces)		45.5	59.1	13.6	0.81
Katanga					
	Haut Lomami	57.1	57.1	0.0	0.39
Kasai					
	Kasai Central	42.9	57.1	14.3	0.32
	Lomami	0.0	100.0	100.0	1.00

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

A reliable means of communication is critical for HZ offices to carry out their oversight and reporting functions. Tables 2.7a and 2.7b display the percentage of HZ offices by province that had cellular network coverage. Overall, there was a 10 PP increase in HZ offices reporting cellular network access (24.3% in 2019 to 35.0% in 2024; p-value = 0.10). Both Sud Kivu and Sankuru experienced statistically significant increases in cellular network coverage (Table 2.7a). Across the three provinces surveyed in 2021 and 2024, an overall decline in cellular network coverage was observed, although not statistically significant (Table 2.7b).

Table 2.7a. Cellular network availability at health zone offices, by province and survey round

		Matched panel (n = 103)				
		2019%	2021%	2024%	PP diff (209 vs 2024)	p-value (2019 vs 2024)
Overall (6 provinces)		24.3	42.7	35.0	10.7	0.10
Eastern Congo						
	Sud Kivu	32.0	48.0	56.0	24.0	0.09*
	Tanganyika	55.6	55.6	22.2	-33.3	0.33
Katanga						
	Haut Katanga	14.8	40.7	11.1	-3.7	1.00
	Lualaba	0.0	18.2	18.2	18.2	0.48
Kasai						
	Sankuru	33.3	66.7	66.7	33.3	0.07*
	Kasai Oriental	18.8	25.0	31.3	12.5	0.69

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Table 2.7b. Cellular network availability at health zone offices, by province and survey round

		Matched panel (n = 56)			
		2021%	2024%	PP diff (2021 vs 2024)	p-value (2021 vs 2024)
Overall (3 provinces)		26.8	25.0	-1.8	0.83
Katanga					
	Haut Lomami	31.3	18.8	-12.5	0.69
Kasai					
	Kasai Central	30.8	19.2	-11.5	0.34
	Lomami	14.3	42.9	28.6	0.21

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

HZ offices reporting Internet connectivity increased sharply across all provinces, although most increases were between 2019 and 2021. Overall, there was a 38.8 PP increase (p-value < 0.01), with statistically significant increases in Sud Kivu, Haut Katanga, Lualaba, Sankuru, and Kasai Oriental (Table 2.8a). At the time of the 2024 survey, at least 84 percent of panel HZ offices reported Internet connections across the six surveyed provinces in 2019 and 2024 (Table 2.8a). Notably, Tanganyika, which made significant progress between 2019 and 2021, saw a reduction in Internet availability between 2021 and 2024 of 33 PPs. Across the three provinces surveyed only in 2021 and 2024, there were no differences in Internet connectivity overall, although Internet connectivity was already high in 2021 (Table 2.8b).

Despite progress in Internet access, connectivity was generally reported at less than 8 hours per day (Tables 2.9a and 2.9b); however, there was a significant increase of 36.3 PPs in offices reporting eight-hour connectivity between the 2019 and 2024 surveys (p-value < 0.01). All provinces surveyed reported increases in Internet availability between 2019 and 2024.

Table 2.8a. Internet connectivity at health zone offices, by province and survey round

		Matched panel (n = 103)				
		2019%	2021%	2024%	PP diff (2019 vs 2024)	p-value (2019 vs 2024)
Overall (6 provinces)		45.6	90.3	84.5	38.8	<0.01***
Eastern Congo						
	Sud Kivu	56.0	80.0	84.0	28.0	0.03**
	Tanganyika	44.4	100.0	66.7	22.2	0.64
Katanga						
	Haut Katanga	63.0	96.3	96.3	33.3	<0.01***
	Lualaba	18.2	90.9	63.6	45.5	0.04**
Kasai						
	Sankuru	13.3	93.3	86.7	73.3	<0.01***
	Kasai Oriental	50.0	87.5	87.5	37.5	0.02**

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Table 2.8b. Internet connectivity at health zone offices, by province and survey round

		Matched panel (n = 56)			
		2021%	2024%	PP diff (2021 vs 2024)	p-value (2021 vs 2024)
Overall (3 provinces)		89.3	89.3	0.0	1.00
Katanga					
	Haut Lomami	93.8	93.8	0.0	1.00
Kasai					
	Kasai Central	84.6	88.5	3.9	1.00
	Lomami	92.9	85.7	-7.1	1.00

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Table 2.9a. Internet connectivity for at least eight hours per day at health zone offices, by province and survey round

		Matched panel (n = 102)				
		2019%	2021%	2024%	PP diff (2019 vs 2024)	p-value (2019 vs 2024)
Overall (6 provinces)		10.8	39.2	47.1	36.3	<0.01***
Eastern Congo						
	Sud Kivu	4.0	32.0	60.0	56.0	<0.01***
	Tanganyika	0.0	33.3	33.3	33.3	0.21
Katanga						
	Haut Katanga	22.2	59.3	48.2	25.9	0.05**
	Lualaba	9.1	45.5	36.4	27.3	0.15
Kasai						
	Sankuru	0.0	21.4	42.9	42.9	0.01*
	Kasai Oriental	18.8	31.3	43.8	25.0	0.13

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Table 2.9b. Internet connectivity for at least eight hours per day at health zone offices, by province and survey round

		Matched panel (n = 56)			
		2021%	2024%	PP diff (2021 vs 2024)	p-value (2021 vs 2024)
Overall (3 provinces)		28.6	53.6	25.0	0.01**
Katanga					
	Haut Lomami	31.3	68.8	37.5	0.03**
Kasai					
	Kasai Central	30.8	50.0	19.2	0.16
	Lomami	21.4	42.9	21.4	0.42

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Health Zone Offices' PICAL Participation and Score

One hundred and three HZs were assessed on whether they had ever participated in a PICAL assessment at both the 2019 and 2024 survey times. A nearly 20 PP increase ($p < 0.01$) was noted for HZ offices participating in PICAL assessments at the time of the 2024 survey compared with 2019, a statistic unchanged from 2019 to 2021 (Table 2.10a). Of those matched HZ offices reporting involvement in a PICAL assessment, in 2019 every facility reported that the PICAL assessment occurred in the previous six months. However, during the 2024 survey, 76 percent of HZ offices noted that the last PICAL assessment occurred more than six months ago, and 60 percent reported that it was more than a year since the last PICAL assessment (data not shown). Among the matched HZ office pairs, all reported receiving their PICAL scores (Table 2.11a and Table 2.11b). Although all HZ offices that participated in the PICAL assessment reported receiving a PICAL score after the assessment, at the time of the 2024 survey, only 42 percent were able to report these scores:

- Katuba HZ in Haut Katanga province reported receiving a score of 58.
- Malemba Nkulu HZ in Haut Lomami province reported receiving a score of 55.
- Mpokolo HZ in Kasai Oriental province reported receiving a score of 17.
- Bipemba HZ in Kasai Oriental province reported receiving a score of 44.
- Kananga HZ in Kasai Central province reported receiving a score of 90.
- Katoka HZ in Kasai Central province reported receiving a score of 80.
- Lualaba HZ in Lualaba province reported receiving a score of 77.
- Kalenda HZ in Lomami province reported receiving a score of 70.
- Kamiji HZ in Lomami province reported receiving a score of 6.
- Luputa HZ in Lomami province reported receiving a score of 5.
- Kalambayi Kabanga HZ in Lomami province reported receiving a score of 46.
- Uvira HZ in Sud Kivu province reported receiving a score of 8.
- Bagira HZ in Sud Kivu province reported receiving a score of 68.

The survey question did not detail how to report the PICAL score; therefore, it is not clear whether the scores reported were the HZ offices' composite score for all four dimensions of capacity that were assessed, or for a sub-set of dimensions. The maximum possible score for the full set of dimensions is 170.

Table 2.10a. Health zone offices participation in PICAL assessments, by province and survey round

		Matched panel (n = 103)				
		2019%	2021%	2024%	PP diff (2019 vs 2024)	p-value (2019 vs 2024)
Overall (6 provinces)		4.9	24.3	24.3	19.4	<0.01***
Eastern Congo						
	Sud Kivu	0.0	4.0	20.0	20.0	0.05*
	Tanganyika	0.0	33.3	11.1	11.1	1.00
Katanga						
	Haut Katanga	14.8	37.0	25.9	11.1	0.31
	Lualaba	9.1	18.2	18.2	9.1	0.59

		Matched panel (n = 103)				
		2019%	2021%	2024%	PP diff (2019 vs 2024)	p-value (2019 vs 2024)
Kasai						
	Sankuru	0.0	20.0	33.3	33.3	0.04**
	Kasai Oriental	0.0	37.5	31.3	31.3	0.04**

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Table 2.10b. Health zone offices participation in PICAL assessments, by province and survey round

		Matched panel (n = 56)			
		2021%	2024%	PP diff (2021 vs 2024)	p-value (2021 vs 2024)
Overall (3 provinces)		23.2	26.8	3.6	0.66
Katanga					
	Haut Lomami	37.5	18.8	-18.8	0.43
Kasai					
	Kasai Central	15.4	19.2	3.9	1.00
	Lomami	21.4	50.0	28.6	0.11

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Table 2.11a. Health zone offices that received PICAL assessment scores, by province and survey round, among those that had participated in a PICAL assessment

		Matched panel (n = 2)				
		2019%	2021%	2024%	PP diff (209 vs 2024)	p-value (2019 vs 2024)
Overall (2 provinces)		50.0	100.0	100.0	50.0	0.73
Eastern Congo						
	Sud Kivu					
	Tanganyika	100.0	100.0	100.0	0.0	1.00
Katanga		0.0	100.0	100.0	100.0	0.25
	Haut Katanga					
	Lualaba					
Kasai						
	Sankuru					
	Kasai Oriental					

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Table 2.11b. Health zone offices that received PICAL assessment scores, by province and survey round, among those that had participated in a PICAL assessment

	Matched panel (n = 5)			
	2021%	2024%	PP diff (2021 vs 2024)	p-value (2021 vs 2024)
Overall (3 provinces)	100.0	100.0	0.0	0.51
Katanga				
Haut Lomami	100.0	100.0	0.0	1.00
Kasai				
Kasai Central	100.0	100.0	0.0	1.00
Lomami	100.0	100.0	0.0	1.00

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Offices and Health Facilities That Were Visited in a Supervisory Capacity by a Higher-Level Authority in the Prescribed Time Frame

The government-run health system in the DRC is designed to have a cascade of supervision: the national level supervises the provincial health offices, which in turn supervise the HZ offices. The HZ offices are primarily responsible for supervising hospitals and HCs. In 2019, three of the six surveyed provincial health offices reported that they were visited by national-level authorities in the prescribed six completed calendar months before the survey (Table 2.12). In 2024, all but one province (Sankuru) reported receiving a supervision visit.

All but eight HZ offices received supervision visits from the central/national or provincial level in the previous calendar year (2018, 2020, and 2022) at each survey time point (data not shown). Overall, across the 103 matched HZ office pairs between 2019, 2021, and 2024 surveys, there was a significant increase ($p < 0.09$) in the number of offices that reported receiving supervisory visits from a higher-level authority in the previous calendar year (Table 2.13a). However, both Haut Katanga and Kasai Central saw a decline in supervision visits between 2021 and 2024 (Tables 2.13a and 2.13b).

Table 2.12. Provincial health offices receiving higher-level supervision visits in the previous calendar year, by province and survey round

	2019	2021	2024
	N = 6	N = 9	N = 9
Overall	60%	67%	89%
Eastern Congo			
Sud Kivu	Yes	Yes	Yes
Tanganyika	Don't Know	Yes	Yes
Kasai			
Kasai-Central		Yes	Yes
Kasai-Oriental	Yes	Yes	Yes
Lomami		Yes	Yes
Sankuru	Yes	No	No

	2019	2021	2024
	N = 6	N = 9	N = 9
Katanga			
Haut-Katanga	No	No	Yes
Haut-Lomami		Yes	Yes
Lualaba	No	No	Yes

Table 2.13a. Health zone offices receiving higher-level supervision visits in the previous calendar year, by province and survey round

		Matched panel (n = 103)				
		2019%	2021%	2024%	PP diff (2019 vs 2024)	p-value (2019 vs 2024)
Overall (6 provinces)		93.2	98.1	98.1	4.9	0.09*
Eastern Congo						
	Sud Kivu	96.0	100.0	100.0	4.0	1.00
	Tanganyika	100.0	100.0	100.0	0.0	1.00
Katanga						
	Haut Katanga	88.9	96.3	92.6	3.7	1.00
	Lualaba	81.8	100.0	100.0	18.2	0.22
Kasai						
	Sankuru	100.0	93.3	100.0	0.0	1.00
	Kasai Oriental	93.8	100.0	100.0	6.3	1.00

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Table 2.13b. Health zone offices receiving higher-level supervision visits in the previous calendar year, by province and survey round

		Matched panel (n = 56)			
		2021%	2024%	PP diff (2021 vs 2024)	p-value (2021 vs 2024)
Overall (3 provinces)		100.	92.9	-7	0.04**
Katanga					
	Haut Lomami	100.0	100.0	0.0	1.00
Kasai					
	Kasai Central	100.0	84.6	-15.4	0.11
	Lomami	100.0	100.0	0.0	1.00

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

There was a significant decrease in the number of hospitals receiving supervision visits in the previous calendar months from 2019 to 2024 (Table 2.14a). Tanganyika, Haut Katanga, and Lualaba all had statistically significant decreases in supervision visits, with Tanganyika decreasing by 83.3 PPs over the course of the analysis. Changes in hospital supervision patterns from 2021 to 2024 were insignificant overall and within provinces (Table 2.14b).

The same trends can be observed in the number of health facilities receiving higher-level supervision visits

(Tables 2.15a and 2.15b). There was a significant decrease overall in HCs receiving supervisory visits, with only 43.5 percent of panel health facilities in 2024 receiving supervision in the previous month. This trend was observed across all provinces, although results in only Sud Kivu, Haut Katanga, and Lualaba were significant. Between 2021 and 2024, results were mixed, with an increase in Lomami of 8 PPs, whereas Haut Lomami and Kasai Central saw decreases. None of these changes were statistically significant (Table 2.15b).

Table 2.14a. Hospitals receiving higher-level supervision visits (from provincial health office and/or health zone office) in the last completed calendar month, by province and survey round

		Matched panel (n = 75)				
		2019%	2021%	2024%	PP diff (2019 vs 2024)	p-value (2019 vs 2024)
Overall (6 provinces)		42.7	42.7	26.7	-16.0	0.01**
Eastern Congo						
	Sud Kivu	29.2	37.5	29.2	0.0	1.00
	Tanganyika	100.0	50.0	16.7	-83.3	0.04**
Katanga						
	Haut Katanga	47.1	64.7	23.5	-23.5	0.01**
	Lualaba	71.4	28.6	14.3	-57.1	0.02**
Kasai						
	Sankuru	25.0	12.5	12.5	-12.5	1.00
	Kasai Oriental	30.8	46.2	46.2	15.4	0.42

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Table 2.14b. Hospitals receiving higher-level supervision visits (from provincial health office and/or health zone office) in the last completed calendar month, by province and survey round

		Matched panel (n = 14)			
		2021%	2024%	PP diff (2021 vs 2024)	p-value (2021 vs 2024)
Overall (3 provinces)		42.9	42.9	0.0	0.68
Katanga					
	Haut Lomami	50.0	66.7	16.7	1.00
Kasai					
	Kasai Central	60.0	40.0	-20.0	0.33
	Lomami	0.0	0.0	0.0	1.00

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Table 2.15a. Health centers receiving higher-level supervision visits (from provincial health office and/or health zone office) in the last completed calendar month by province and survey round

		Matched panel (n = 131)				
		2019%	2021%	2024%	PP diff (2019 vs 2024)	p-value (2019 vs 2024)
Overall (6 provinces)		67.	48.9	43.5	-24.4	<0.01***
Eastern Congo						
	Sud Kivu	64.7	44.1	50.0	-14.7	0.04**
	Tanganyika	66.7	40.0	33.3	-33.3	0.10
Katanga						
	Haut Katanga	86.1	50.0	44.4	-41.7	<0.01***
	Lualaba	66.7	50.0	50.0	-16.7	0.05**
Kasai						
	Sankuru	12.5	12.5	0.0	-12.5	0.38
	Kasai Oriental	65.4	69.2	50.0	-15.4	0.13

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Table 2.15b. Health centers receiving higher-level supervision visits (from provincial health office and/or health zone office) in the last completed calendar month, by province and survey round

		Matched panel (n = 78)			
		2021%	2024%	PP diff (2021 vs 2024)	p-value (2021 vs 2024)
Overall (3 provinces)		35.9	33.3	-2.6	0.36
Katanga					
	Haut Lomami	52.6	47.4	-5.3	0.22
Kasai					
	Kasai Central	38.2	29.4	-8.8	0.51
	Lomami	20.0	28.0	8.0	0.65

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Frequency of Health Zone Offices' Communication with CODESAs

A binary classification was established for the frequency of communication between HZ office staff and CODESAs: at least monthly versus greater than monthly. Among the 103 matched HZ office pairs that were surveyed at both 2019 and 2024, there virtually no change in the percentage of offices reported to be in communication at least monthly with CODESA groups (Table 2.16a). The overall relationship between these variables was not significant. However, there was a significant increase in communication efforts in Sankuru province (p = 0.04). This means that HZ offices' monthly communication with CODESA groups was dependent on the survey time point for Sankuru province. Between 2021 and 2024, a slight decrease in monthly communication was observed across the 56 matched HZ office pairs, although this decrease was not significant (Table 2.16b).

Table 2.16a. Health zone office communication with CODESAs: at least monthly frequency, by province and survey round

		Matched panel (n = 103)				
		2019%	2021%	2024%	PP diff (201 vs 2024)	p-value (2019 vs 2024)
Overall (6 provinces)		88.4	95.2	89.3	1	0.81
Eastern Congo						
	Sud Kivu	92.0	92.0	88.0	-4.0	1.00
	Tanganyika	100.0	88.9	77.8	-22.2	0.47
Katanga						
	Haut Katanga	92.6	92.6	88.9	-3.7	1.00
	Lualaba	90.9	100.0	90.9	0.0	1.00
Kasai						
	Sankuru	66.7	100.0	100.0	33.3	0.04**
	Kasai Oriental	87.5	100.0	87.5	0.0	1.00

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Table 2.16b. Health zone office communication with CODESAs: at least monthly frequency, by province and survey round

		Matched panel (n = 56)			
		2021%	2024%	PP diff (2021 vs 2024)	p-value (2021 vs 2024)
Overall (3 provinces)		92.9	91.1	-1.8	0.73
Katanga					
	Haut Lomami	87.5	75.0	-12.5	0.65
Kasai					
	Kasai Central	96.2	96.2	0.0	1.00
	Lomami	92.9	100.0	7.1	1.00

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Questions on health facility administration's knowledge and perceptions of CODESA groups were not asked in 2019 and, as such, no comparisons could be made between survey time points for certain questions about CODESA groups. However, in both 2021 and 2024, nearly all health system survey participants reported involvement in CODESA group member orientation (i.e., communicating CODESA tasks/roles) (Table 2.17). There was a statistically significant overall increase in the involvement of the health facilities in CODESA group member orientation (p = 0.01).

Table 2.17. Percentage of health facilities that participated in orientation of CODESA members, by province and survey round

Province		Matched panel (n = 437) 2021%	2024%	PP diff (2021 vs 2024)	p-value (2021 vs 2024)
Overall	Overall	96.1	97.5	1.4	0.01**
Eastern Congo					
	Sud Kivu	90.1	96.7	6.6	0.40
	Tanganyika	100.0	88.9	-11.1	0.11
Kasai					
	Kasai Oriental	98.1	100.0	1.9	0.12
	Kasai Central	100.0	98.4	-1.6	1.00
	Lomami	100.0	100.0	0.0	1.00
	Sankuru	100.0	100.0	0.0	0.24
Katanga					
	Haut Katanga	96.7	96.7	0.0	0.30
	Haut Lomami	82.8	93.1	10.3	0.24
	Lualaba	100.0	100.0	0.0	0.49

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

The level of CODESA involvement in health facility management was categorized as "a lot," "a little," and "none" (Table 2.18a). Findings between 2021 and 2024 indicate a modest, significant increase in health facilities reporting "a lot" of CODESA involvement in facility management (Table 2.18b, p=0.01). At a provincial level, both Tanganyika and Haut Lomami reported statistically significant increases in CODESA involvement in health facility operations.

Table 2.18a. Health facility report of CODESA involvement in health facility operations/management decisions, by province and survey round

Province	2021 (N = 603) A lot	A little	None	2024 (N = 600) A lot	A little	None
Overall	292 (41.9%)	198 (28.4%)	19 (2.7%)	391 (54.5%)	170 (23.7%)	39 (5.4%)
Eastern Congo						
Sud Kivu	50 (38.5%)	44 (33.8%)	1 (0.77%)	73 (53.7%)	37 (27.2%)	9 (6.62%)
Tanganyika	11 (25.0%)	20 (45.5%)	- (-%)	26 (59.1%)	8 (18.2%)	- (-%)
Katanga						
Haut Katanga	39 (37.1%)	29 (27.6%)	8 (7.62%)	53 (50.0%)	36 (34.0%)	10 (9.43%)
Lualaba	24 (42.9%)	14 (25.0%)	2 (3.57%)	32 (57.1%)	11 (19.6%)	2 (3.57%)
Haut Lomami	26 (44.8%)	16 (27.6%)	- (-%)	47 (73.4%)	4 (6.2%)	1 (1.56%)
Kasai						
Sankuru	16 (25.4%)	29 (46.0%)	2 (3.17%)	19 (29.7%)	27 (42.2%)	6 (9.38%)
Kasai Oriental	44 (57.9%)	8 (10.5%)	4 (5.26%)	46 (60.5%)	15 (19.7%)	5 (6.58%)
Kasai Central	53 (52.0%)	22 (21.6%)	2 (1.96%)	59 (55.1%)	24 (22.4%)	1 (0.93%)
Lomami	29 (46.0%)	16 (25.4%)	- (-%)	36 (56.2%)	8 (12.5%)	5 (7.81%)

Table 2.18b. Changes in high CODESA involvement in health facility operations/management decisions, by province and survey round

		Matched panel (n = 437)			
Province		**2021%**	**2024%**	**PP diff (2021 vs 2024)**	**p-value (2021 vs 2024)**
Overall	Overall	58.1	68.0	9.8	0.01**
Eastern Congo					
	Sud Kivu	51.7	68.1	16.5	0.20
	Tanganyika	33.3	77.8	44.4	<0.01***
Kasai					
	Kasai Oriental	80.8	75.0	-5.8	0.27
	Kasai Central	73.0	71.4	-1.6	0.85
	Lomami	65.9	73.2	7.3	0.34
	Sankuru	30.8	35.9	5.1	0.80
Katanga					
	Haut Katanga	51.7	53.3	1.7	0.77
	Haut Lomami	62.1	86.2	24.1	<0.01***
	Lualaba	62.9	82.9	20.0	0.28

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

The community scorecard program was managed by the CODESA; it provided an additional accountability mechanism for health facilities. Awareness of the community scorecard program significantly increased among health facility respondents between 2019 and 2024 (Table 2.19a, $p < 0.01$). A similar, significant increase was observed among facilities surveyed in 2021 and 2024 (Table 2.19b).

Table 2.19a. Percentage of health facilities that were aware of the community scorecard program, by province and survey round

		Matched panel (n = 412)				
		2019%	2021%	2024%	PP diff (2019 vs 2024)	p-value (2019 vs 2024)
Overall (6 provinces)		5.8	8.7	24.3	18.5	<0.01***
Eastern Congo						
	Sud Kivu	7.6	13.6	28.8	21.2	<0.01***
	Tanganyika	5.6	0.0	11.1	5.6	0.67
Katanga						
	Haut Katanga	5.8	10.5	24.4	18.6	<0.01***
	Lualaba	2.1	8.5	19.2	17.0	0.01**
Kasai						
	Sankuru	7.1	1.8	23.2	16.1	0.02**
	Kasai Oriental	4.4	8.7	27.5	23.2	<0.01***

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Table 2.19b. Percentage of health facilities that were aware of the community scorecard program, by province and survey round

		Matched panel (n = 182)			
		2021%	2024%	PP diff (2021 vs 2024)	p-value (2021 vs 2024)
Overall (3 provinces)		18.7	31.9	13.	<0.01***
Katanga					
	Haut Lomami	2.2	17.8	15.6	0.03**
Kasai					
	Kasai Central	32.9	45.1	12.2	0.11
	Lomami	10.9	23.6	12.7	0.08*

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Provincial Health Office Attendance at Technical Meetings and Communications Frequency with Other Health Offices

Provincial health offices may also coordinate with their HZ offices and with other provincial health offices. Some participated in technical meetings with the MOH or NGOs. All provincial health offices reported attending technical meetings at least annually in all three survey waves (Table 2.20). In addition, in all but one instance, provincial health offices reported at least monthly communication with HZ offices (Table 2.21). Kasai Central reported quarterly communication frequency with HZ offices at the time of the 2021 survey. Communication with other provincial health offices was more mixed, ranging from unknown (Sud Kivu and Sankuru) to monthly, quarterly, or semiannually (Table 2.22). At the time of the 2024 survey, five of the nine surveyed provincial health offices were either not sure of their frequency of communication with other provincial health offices, or reported that communication was irregular.

Table 2.20. Provincial health office attendance at technical meetings, by province and survey round

Province		2019	2021	2024
Overall		100%	100%	100%
Eastern Congo				
	Sud Kivu	Yes	Yes	Yes
	Tanganyika	Yes	Yes	Yes
Katanga				
	Haut-Katanga	Yes	Yes	Yes
	Haut-Lomami		Yes	Yes
	Lualaba	Yes	Yes	Yes
Kasai				
	Kasai-Central		Yes	Yes
	Kasai-Oriental	Yes	Yes	Yes
	Lomami		Yes	Yes
	Sankuru	Yes	Yes	Yes

Table 2.21. Provincial health office frequency of communication with health zone offices, by province and survey round

Province		2019	2021	2024
Eastern Congo				
	Sud Kivu	Monthly	Monthly	Monthly
	Tanganyika	Monthly	Monthly	Monthly
Katanga				
	Haut-Katanga	Monthly	Monthly	Monthly
	Haut-Lomami		Monthly	Monthly
	Lualaba	Monthly	Monthly	Monthly
Kasai				
	Kasai-Central		Quarterly	Monthly
	Kasai-Oriental	Monthly	Monthly	Monthly
	Lomami		Monthly	Monthly
	Sankuru	Monthly	Monthly	Monthly

Table 2.22. Provincial health office frequency of communication with other provincial health offices, by province and survey round

Province		2019	2021	2024
Eastern Congo				
	Sud Kivu	Irregularly	Irregularly	Don't know
	Tanganyika	Quarterly	Monthly	Monthly
Katanga				
	Haut-Katanga	Monthly	Twice a year	Monthly
	Haut-Lomami		Twice a year	Irregularly
	Lualaba	Quarterly	Quarterly	Irregularly
Kasai				
	Kasai-Central		Irregularly	Irregularly
	Kasai-Oriental	Monthly	Irregularly	Quarterly
	Lomami		Monthly	Monthly
	Sankuru	Quarterly	Irregularly	Don't know

Frequency of Health Zone Offices' Communication with Other Health Zone Offices

A binary classification was established for the frequency of communication between HZ offices and other HZ offices: at least monthly versus greater than monthly. Among the 101 matched HZ office pairs that were surveyed in 2019, 2021, and 2024, a slight, non-significant decrease was noted for offices reporting to be in communication at least monthly with CODESA groups (Table 2.23a). Bivariate comparisons between the 2019 and 2024 results showed a significant increase in communication reported by Sud Kivu of 34.8 PPs. Similarly, Lomami reported a significant increase between 2021 and 2024 of 57.1 PPs (Table 2.23b).

Table 2.23a. Health zone office communication with other health zone offices: at least monthly frequency, by province and survey round

		Matched panel (n = 101)				
		2019%	2021%	2024%	PP diff (2019 vs 2024)	p-value (2019 vs 2024)
Overall (6 provinces)		43.	44.6	41.6	-2.0	0.86
Eastern Congo						
	Sud Kivu	8.7	30.4	43.5	34.8	0.01**
	Tanganyika	44.4	66.7	44.4	0.0	1.00
Katanga						
	Haut Katanga	40.7	48.2	25.9	-14.8	0.25
	Lualaba	81.8	54.6	63.6	-18.2	0.64
Kasai						
	Sankuru	66.7	46.7	53.3	-13.3	0.46
	Kasai Oriental	50.0	37.5	37.5	-12.5	0.48

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Table 2.23b. Health zone office communication with other health zone offices: at least monthly frequency, by province and survey round

		Matched panel (n = 56)			
		2021%	2024%	PP diff (2021 vs 2024)	p-value (2021 vs 2024)
Overall (3 provinces)		44.	60.7	16.1	0.09
Katanga					
	Haut Lomami	43.8	68.8	25.0	0.15
Kasai					
	Kasai Central	50.0	38.5	-11.5	0.40
	Lomami	35.7	92.9	57.1	<0.01***

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Virtually all HZ offices participated in comité de gestion (COGE; management committee) meetings at both survey time points (Tables 2.24a and 2.24b) and, as such, no significant differences were noted between the surveys. At the time of the 2021 survey, eight of nine provinces reported 100 percent HZ office representation at COGE meetings.

Table 2.24a. Health zone office participation in COGE provincial meetings, by province and survey round

		Matched panel (n = 103)				
		2019%	2021%	2024%	PP diff (2019 vs 2024)	p-value (2019 vs 2024)
Overall (6 provinces)		98.	99.0	100.0	1.9	0.15
Eastern Congo						
	Sud Kivu	100.0	96.0	100.0	0.0	1.00
	Tanganyika	100.0	100.0	100.0	0.0	1.00
Katanga						
	Haut Katanga	96.3	100.0	100.0	3.7	1.00
	Lualaba	100.0	100.0	100.0	0.0	1.00
Kasai						
	Sankuru	100.0	100.0	100.0	0.0	1.00
	Kasai Oriental	93.8	100.0	100.0	6.3	1.00

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Table 2.24b. Health zone office participation in COGE provincial meetings, by province and survey round

		Matched panel (n = 56)			
		2021%	2024%	PP diff (2021 vs 2024)	p-value (2021 vs 2024)
Overall (3 provinces)		100.0	100.0	0.0	1.00
Katanga					
	Haut Lomami	100.0	100.0	0.0	1.00
Kasai					
	Kasai Central	100.0	100.0	0.0	1.00
	Lomami	100.0	100.0	0.0	1.00

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Health Zone Office Management of Mutuelles

The percentage of HZ offices that reported to have kept a list of all *mutuelles* (i.e., health insurance schemes) in their HZ decreased by 12.5 PPs from 2019 to 2024 (Table 2.25a). Moreover, only two provinces (Sud Kivu and Haut Katanga) had matched HZ pairs that were able to provide responses for this question due to the lack of reported existence of *mutuelles* in HZs. Among those HZ offices that kept lists of *mutuelles,* few tracked or kept lists of *mutuelle* members, with a slight, insignificant decrease in reported tracking from 2019 to 2024 (Table 2.26a). Even when focusing on the 2024 survey alone, only 8 percent of reporting HZ offices tracked *mutuelle* members. In 2019, only Sud Kivu and Haut Katanga provinces had HZ offices reporting any health facilities seeking their permission to offer fee reductions to members of *mutuelles;* however, by 2024, Tanganyika and Kasai Oriental also reported doing so (Table 2.27a). Sud Kivu, Lualaba, and Lomami were the only provinces that reported HZ-led supervisor visits specifically for HAs participating in *mutuelles*, with a significant increase of 37.5 PPs overall between 2019 and 2024 (Tables 2.28a and 2.28b).

Table 2.25a. Health zone office tracking of *mutuelles*, by province and survey round

		Matched panel (n = 16)				
		2019%	2021%	2024%	PP di019 vs 2024)	p-value (2019 vs 2024)
Overall (6 provinces)		75.0	43.8	62.5	-12.5	0.45
Eastern Congo						
	Sud Kivu	84.6	53.9	61.5	-23.1	0.14
	Tanganyika	Missing	Missing	Missing		
Katanga						
	Haut Katanga	50.0	0.0	100.0	50.0	0.29
	Lualaba	Missing	Missing	Missing		
Kasai						
	Sankuru	Missing	Missing	Missing		
	Kasai Oriental	Missing	Missing	Missing		

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Table 2.25b. Health zone office tracking of *mutuelles*, by province and survey round

		Matched panel (n = 2)			
		2021%	2024%	PP diff (2021 vs 2024)	p-value (2021 vs 2024)
Overall (3 provinces)		50.	50.0	0.0	1
Katanga					
	Haut Lomami	Missing	Missing		
Kasai					
	Kasai Central	0.0	0.0	0.0	1.00
	Lomami	100.0	100.0	0.0	1.00

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Table 2.26a. Health zone office tracking of *mutuelles* members, by province and survey round

		Matched panel (n = 16)				
		2019%	2021%	2024%	PP diff (2019 v24)	p-value (2019 vs 2024)
Overall (6 provinces)		12.	12.50	25.0	12.5	0.58
Eastern Congo						
	Sud Kivu	15.4	15.4	30.8	15.4	1.00
	Tanganyika	Missing	Missing			
Katanga						
	Haut Katanga	0.0	0.00	0.00	0.0	1.00
	Lualaba	Missing	Missing	Missing		
Kasai						
	Sankuru	Missing	Missing	Missing		
	Kasai Oriental	0.0	0.0	0.0	0.0	1.00

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Table 2.26b. Health zone office tracking of *mutuelles* members, by province and survey round

		Matched panel (n = 2)			
		2021%	2024%	PP diff (2021 vs 2024)	p-value (2021 vs 2024)
Overall (3 provinces)		50.0	50.0	0.0	1.00
Katanga					
	Haut Lomami	Missing	Missing		
Kasai					
	Kasai Central	0.0	0.0	0.0	1.00
	Lomami	100.0	100.0	0.0	1.00

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Table 2.27a. Health facilities seeking permission from health zone offices for service fee reductions, by province and survey round

	Matched panel (n = 103)				
	2019%	2021%	2024%	PP diff (2019 vs 2024)	p-value (2019 vs 2024)
Overall (6 provinces)	10.7	9.7	15.5	4.9	0.31
Eastern Congo					
Sud Kivu	32.0	28.0	44.0	12.0	0.38
Tanganyika	0.0	11.1	22.2	22.2	0.47
Katanga					
Haut Katanga	11.1	7.4	3.7	-7.4	0.61
Lualaba	0.0	0.0	0.0	0.0	1.00
Kasai					
Sankuru	0.0	0.0	0.0	0.0	1.00
Kasai Oriental	0.0	0.0	12.5	12.5	0.48

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Table 2.27b. Health facilities seeking permission from health zone offices for service fee reductions, by province and survey round

	Matched panel (n = 56)			
	2021%	2024%	PP diff (2021 vs 2024)	p-value (2021 vs 2024)
Overall (3 provinces)	14.3	12.5	-1.8	0.78
Katanga				
Haut Lomami	18.8	12.5	-6.3	1.00
Kasai				
Kasai Central	11.5	19.2	7.7	0.70
Lomami	14.3	0.0	-14.3	0.48

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Table 2.28a. Health zone office supervision of *mutuelles*, by province and survey round

		Matched panel (n = 16)				
		2019%	2021%	2024%	PP diff (2019 vs 2024)	p-value (2019 vs 2024)
Overall (6 provinces)		43.	50.0	81.3	37.5	0.01**
Eastern Congo						
	Sud Kivu	53.9	61.5	92.3	38.5	0.24
	Tanganyika	Missing	Missing	Missing		
Katanga						
	Haut Katanga	0.0	0.0	0.0	0.0	1.00
	Lualaba	0.0	0.0	100.0	100.0	0.25
Kasai						
	Sankuru	Missing	Missing	Missing		
	Kasai Oriental	Missing	Missing	Missing		

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Table 2.28b. Health zone office supervision of *mutuelles*, by province and survey round

		Matched panel (n = 2)			
		2021%	2024%	PP diff (2021 vs 2024)	p-value (2021 vs 2024)
Overall (3 provinces)		50.0	50.0	0.0	0.74
Katanga					
	Haut Lomami	Missing	Missing		
Kasai					
	Kasai Central	0.0	0.0	0.0	1.00
	Lomami	100.0	100.0	0.0	1.00

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Timing of Health Office Reporting Its Most Recent MAPEPI DHIS2 Case

A binary classification was established to assess the timing of report submission on diseases with epidemic potential (MAPEPI; *maladies à potentiel épidémique*) within 24 hours versus greater than 24 hours. At the time of the 2019 and 2024 surveys, roughly two-thirds of provincial health offices reported that they submitted MAPEPI cases within 24 hours of identification (Table 2.29). Sankuru and Tanganyika provinces no longer met the criteria in 2024, whereas Kasai-Oriental and Haut Katanga achieved timely reporting rates by 2024. Kasai-Central did not achieve timely reporting across any survey wave.

There was virtually no change in the percentage of HZ offices reporting that they had submitted the MAPEPI within 24 hours of case identification, increasing from 74.5 percent to 77.5 percent of surveyed HZ offices (Table 2.30a). Bivariate comparisons showed that the overall relationship between 2019 and 2024 values was not significant, either overall or at the provincial level. However, there was a significant increase in the percentage of HZ offices reporting timely submission of MAPEPI cases in Lomami, increasing from 46.7 percent in 2021 to 93.3 percent in 2024 (p = 0.01) (Table 2.30b).

Table 2.29. Provincial health office reporting of most recent MAPEPI DHIS2 cases within 24 hours, by province and survey round

Province		2019 N = 6	2021 N = 9	2024 N = 9
Eastern Congo		60.0	66.7	66.7
	Sud Kivu	Yes	Yes	Yes
	Tanganyika	Yes	Yes	No
Katanga				
	Haut-Katanga	No	Yes	Yes
	Haut-Lomami		Yes	Yes
	Lualaba		Yes	Yes
Kasai				
	Kasai-Central		No	No
	Kasai-Oriental	No	No	Yes
	Lomami		Yes	Yes
	Sankuru	Yes	No	No

Table 2.30a. Health zone office reporting of most recent MAPEPI DHIS2 cases, by province and survey round

		Matched panel (n = 102)				
		2019%	2021%	2024%	PP diff (2019 vs 2024)	p-value (2019 vs 2024)
Overall (6 provinces)		74.5	80.4	77.5	2.9	0.62
Eastern Congo						
	Sud Kivu	81.5	81.5	66.7	-14.8	0.21
	Tanganyika	50.0	75.0	87.5	37.5	0.28
Katanga						
	Haut Katanga	81.5	92.6	81.5	0.0	1.00
	Lualaba	72.7	45.5	81.8	9.1	1.00
Kasai						
	Sankuru	53.9	92.3	84.6	30.8	0.20
	Kasai Oriental	81.3	75.0	75.0	-6.3	1.00

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Table 2.30b. Health zone office reporting of most recent MAPEPI DHIS2 cases, by province and survey round

		Matched panel (n = 57)			
		2021%	2024%	PP diff (2021 vs 2024)	p-value (2021 vs 2024)
Overall (3 provinces)		70.2	80.7	10.5	0.19
Katanga					
	Haut Lomami	62.5	68.8	6.3	0.71
Kasai					
	Kasai Central	88.5	80.8	-7.7	0.70
	Lomami	46.7	93.3	46.7	0.01**

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

When asked about common reasons why MAPEPI reports may not be submitted on time, most HZ offices cited the lack of communication means (no cell or Internet) or lack of transportation. Overall, 52.9 percent of HZ offices cited the lack of communication in 2019, which increased to 60.8 percent in 2024—a non-significant increase (Table 2.31a). All provinces except Kasai Central reported an increase in the lack of communication between 2021 and 2024, with significant changes observed between 2021 and 2024 for both Haut Lomami and Lomami (Table 2.31b). Focusing on 2024 data only, 60 percent of HZ offices cited communication issues as a potential reason for late submission of MAPEPI reports, which was most common in Tanganyika (87.5%) and least common in Kasai Central (38.5%). HZ offices also commonly reported transportation issues as a reason for late submissions. Overall, there was negligible change in this reported issue from 2019 to 2024, with a non-significant decrease of nearly 5.0 PPs (Table 2.32a). However, between 2021 and 2024, Haut Lomami reported a significant increase in transportation difficulties, rising from 25 percent to 62.5 percent (p = 0.03) (Table 2.32b). Among the reporting HZ offices across the nine surveyed provinces in 2024, Haut Lomami cited the most transportation issues at 62.5 percent of instances, whereas Sankuru reported the lowest issues in 15.4 percent of instances.

Table 2.31a. Health zone office reason for late submission of MAPEPI DHIS2 cases (communication issues), by province and survey round

	Matched panel (n = 102)				
	2019%	2021%	2024%	PP diff (2019 vs 2024)	p-value (2019 vs 2024)
Overall (6 provinces)	52.9	46.1	60.8	7.8	0.26
Eastern Congo					
Sud Kivu	66.7	55.6	74.1	7.4	0.55
Tanganyika	75.0	37.5	87.5	12.5	1.00
Katanga					
Haut Katanga	48.2	48.2	51.9	3.7	0.79
Lualaba	27.3	36.4	45.5	18.2	0.66
Kasai					
Sankuru	69.2	53.9	61.5	-7.7	1.00
Kasai Oriental	31.3	31.3	50.0	18.8	0.28

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Table 2.31b. Health zone office reason for late submission of MAPEPI DHIS2 cases (communication issues), by province and survey round

	Matched panel (n = 57)			
	2021%	2024%	PP diff (2021 vs 2024)	p-value (2021 vs 2024)
Overall (3 provinces)	40.4	56.1	15.8	0.09
Katanga				
Haut Lomami	37.5	75.0	37.5	0.03**
Kasai				
Kasai Central	53.9	38.5	-15.4	0.27
Lomami	20.0	66.7	46.7	0.01**

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Table 2.32a. Health zone office reason for late submission of MAPEPI DHIS2 cases (transportation issues), by province and survey round

	Matched panel (n = 102)				
	2019%	2021%	2024%	PP diff (2019 v24)	p-value (2019 vs 2024)
Overall (6 provinces)	28.4	28.4	23.5	-4.9	0.42
Eastern Congo					
Sud Kivu	14.8	14.8	14.8	0.0	1.00
Tanganyika	37.5	50.0	62.5	25.0	0.62
Katanga					
Haut Katanga	22.2	33.3	22.2	0.0	1.00
Lualaba	27.3	36.4	18.2	-9.1	1.00
Kasai					
Sankuru	38.5	30.8	15.4	-23.1	0.38
Kasai Oriental	50.0	25.0	31.3	-18.8	0.28

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Table 2.32b. Health zone office reason for late submission of MAPEPI DHIS2 cases (transportation issues), by province and survey round

	Matched panel (n = 57)			
	2021%	2024%	PP diff (2021 vs 2024)	p-value (2021 vs 2024)
Overall (3 provinces)	19.	33.3	14.0	0.09
Katanga				
Haut Lomami	25.0	62.5	37.5	0.03**
Kasai				
Kasai Central	15.4	15.4	0.0	1.00
Lomami	20.0	33.3	13.3	0.68

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Strengthened Capacity of CSOs and Community Structures to Provide Health System Oversight: Community Monitoring and Oversight

Questions concerning CODESA groups were not asked in 2019 and, as such, comparisons are made between survey time points collected in 2021 and 2024. Surveyed CODESA groups were asked several questions related to community scorecard training and involvement.

By the 2024 survey, 63.96 percent of CODESA members reported having received training on the development and use of the community scorecard approach for social accountability. This represents an increase of 11.1 PPs between 2021 and 2024; however, this change was not statistically significant (Table 2.33a). CODESA member responses indicated increases in the implementation of community scorecard activities in Sud Kivu, Kasai Central, Haut Katanga, Sankuru, Lomami, and Kasai Oriental, but not significantly. A notable, but non-significant decrease was reported for Tanganyika.

The 2024 survey results showed a decline in the percentage of CODESA members who reported receiving community scorecard training in the past 24 months, decreasing from 81.5 percent in 2021 to 57.7 percent in 2024 (Table 2.33b). This decline of 23.8 PPs was statistically significant. Statistically non-significant decreases were seen in nearly all provinces, except for a non-significant slight increase in Sud Kivu. Reports of receiving

scorecard training remained stable in Lualaba and Lomami.

By 2024, 29.76 percent of CODESA members reported having participated in the implementation of community scorecard activities in the past 12 months, a statistically significant decrease of 20.2 PPs from 50 percent in 2021 (Table 2.33c). Tanganyika and Haut Katanga saw significant declines in participation, with Tanganyika dropping by 87.5 PPs and Haut Katanga by 65.15 PPs, whereas Haut Lomami saw a non-significant decline of 66.67 PPs. Sud Kivu and Kasai Oriental experienced smaller non-significant reductions, whereas Kasai Central showed a modest non-significant increase. Lomami reported a significant rise in participation from 2021 to 2024 (p=0.053).

Table 2.33a. CODESA implementation of community scorecard activities, by province and survey round (received training on the development and use of a community scorecard approach)

		Matched Panel 2021 (n=53)	Matched Panel 2024 (n=83)		
		2021%	2024%	PP diff (2021 vs 2024)	p-value (2021 vs 2024)
Overall (9 provinces)		52.8	63.	11.0	0.201
Eastern Congo					
	Sud Kivu	36.8	59.4	22.5	0.12
	Tanganyika	100.0	71.4	-28.6	0.391
Katanga					
	Haut Katanga	50.0	63.6	13.6	0.585
	Lualaba	100.0	100.0	0.0	---
Kasai					
	Sankuru	0.0	50.0	50.0	---
	Kasai Oriental	50.0	54.6	4.6	0.821
Katanga					
	Haut Lomami	100.0	100.0	0.0	---
Kasai					
	Kasai Central	50.0	61.5	11.5	0.682
	Lomami	75.0	100.0	25.0	0.35

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Table 2.33b. CODESA implementation of community scorecard activities, by province and survey round (community score card training provided in the past 24 months)

		Matched Panel 2021 (n=27)	Matched Panel 2024 (n=52)		
		2021%	2024%	PP diff (2021 vs 2024)	p-value (2021 vs 2024)
Overall (9 provinces)		81.	57.	-23.8	0.034**
Eastern Congo					
	Sud Kivu	57.1	57.9	0.8	0.973
	Tanganyika	100.0	40.0	-60.0	0.147
Katanga					
	Haut Katanga	100.0	57.1	-42.9	0.175
	Lualaba	100.0	100.0	0.0	---
Kasai					
	Sankuru	0.0	100.0	100.0	---
	Kasai Oriental	85.7	33.3	-52.4	0.053*
Katanga					
	Haut Lomami	100.0	33.3	-66.7	0.248
Kasai					
	Kasai Central	100.0	85.7	-14.3	0.686
	Lomami	66.7	66.7	0.0	1

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Table 2.33c. CODESA implementation of community scorecard activities, by province and survey round (participated in the implementation of a community scorecard activity in the past 12 months)

		Matched Panel 2021 (n=52)	Matched Panel 2024 (n=84)		
		2021%	2024%	PP diff (2021 vs 2024)	p-value (2021 vs 2024)
Overall (9 provinces)		50	29.76	-20.24	0.018**
Eastern Congo					
	Sud Kivu	36.84	28.12	-8.72	0.517
	Tanganyika	100	12.5	-87.5	0.016**
Katanga					
	Haut Katanga	83.33	18.18	-65.15	0.009***
	Lualaba	100	100	0	---
Kasai					
	Sankuru	0	0	0	---
	Kasai Oriental	53.85	36.36	-17.49	0.392
Katanga					
	Haut Lomami	100	33.33	-66.67	0.248
Kasai					
	Kasai Central	25	38.46	13.46	0.622
	Lomami	0	66.67	66.67	0.053*

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

By 2024, 69.05 percent of CODESA members surveyed overall reported having access to health facility data on patient experiences or facility malfeasance, an increase of 10.56 PPs from 58.49 percent in 2021, but this change was not statistically significant (Table 2.34a). Sud Kivu and Kasai Oriental saw non-significant increases in access to patient feedback, whereas Haut Lomami reported a significant increase (p=0.046). Kasai Central also experienced a substantial significant increase (p=0.057). Tanganyika, Haut Katanga, Lualaba, and Lomami saw declines, with Lualaba dropping to 0 percent in 2024, although not statistically significant. No changes were observed in Sankuru, which reported zero access to patient feedback about facility malfeasance. Feedback may have taken the form of suggestions from the “suggestion box,” notes from meetings/interviews with patients, patient surveys, or information from anti-corruption hotlines.

Table 2.34a. CODESA access to patient feedback and/or information about facility malfeasance, by province and survey round

		Matched Panel 2021 (n=53)	Matched Panel 2024 (n=84)		
		2021%	2024%	PP diff (2021 vs 2024)	p-value (2021 vs 2024)
Overall (9 provinces)		58.49	69.05	10.56	0.207
Eastern Congo					
	Sud Kivu	63.16	81.25	18.09	0.152
	Tanganyika	50	25	-25	0.49
Katanga					
	Haut Katanga	83.33	63.64	-19.69	0.394
	Lualaba	66.67	0	-66.67	0.248
Kasai					
	Sankuru	0	0	0	---
	Kasai Oriental	50	72.73	22.73	0.25
Katanga					
	Haut Lomami	0	100	100	0.046**
Kasai					
	Kasai Central	25	76.92	51.92	0.057*
	Lomami	75	66.67	-8.33	0.809
Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01					

By 2024, 93.1 percent of CODESA members reported attempting to act on feedback from patients, a slight decrease of 6.9 PPs from 100 percent in 2021, although this change was not statistically significant (Table 2.34b). Sud Kivu experienced a minor decline in taking action to respond to patient feedback and/or information about facility malfeasance, dropping by 11.54 PPs to 88.46 percent, which was not statistically significant. Tanganyika, Haut Katanga, Kasai Oriental, Kasai Central, and Lomami all maintained a 100 percent response rate across both years. Haut Lomami reported a 66.67 percent response rate in 2024. Lualaba saw a decrease, with no CODESA members reporting an attempt to act on feedback in 2024. Sankuru did not report any data for either year.

Table 2.34b. CODESA reactions to patient feedback and/or information about facility malfeasance, by province and survey round

		Matched Panel 2021 (n=31)	Matched Panel 2024 (n=58)		
		2021%	2024%	PP diff (2021 vs 2024)	p-value (2021 vs 2024)
Overall (9 provinces)		100	93.1	-6.9	0.135
Eastern Congo					
	Sud Kivu	100	88.46	-11.54	0.22
	Tanganyika	100	100	0	---
Katanga					
	Haut Katanga	100	100	0	---
	Lualaba	100	0	-100	---
Kasai					
	Sankuru	0	0	0	---
	Kasai Oriental	100	100	0	---
Katanga					
	Haut Lomami	0	66.67	66.67	---
Kasai					
	Kasai Central	100	100	0	---
	Lomami	100	100	0	---
Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01					

Percentage of Health Center Workers Who Reported Being Generally Satisfied with Their Jobs

Overall, the percentage of HC workers reporting general job satisfaction increased from 39.2 percent in 2019 to 44.7 percent in 2024, a statistically significant rise of 5.5 PPs (Table 2.35a). This positive trend was more pronounced among female health workers, whose satisfaction increased by 8.4 PPs, from 41.5 percent to 49.9 percent (p=0.010). Male health workers also reported an increase in satisfaction, although the 3 PP rise from 37.6 percent to 40.6 percent was not statistically significant. Significant increases were observed in the Kasai Oriental province and a slightly non-significant increase in Lualaba. Statistically non-significant increases were also seen in Tanganyika and Haut Katanga. However, Sankuru and Sud Kivu saw decreases, but not significantly.

In the provinces added after 2019, overall job satisfaction increased from 44.3 percent in 2021 to 53.9 percent in 2024, a statistically significant change of 9.6 PPs (p=0.003) (Table 2.35b). Female health workers in these provinces saw a significant increase in satisfaction, from 46 percent in 2021 to 60.1 percent in 2024, an increase of 14.1 PPs (p=0.006). Among male health workers, satisfaction increased by 6.3 PPs, from 43.2

percent to 49.5 percent, although this change was not statistically significant. All three provinces saw an increase in HC workers who reported being generally satisfied with their jobs, with a significant increase of 17 PPs reported for Kasai Central (p=0.001).

Table 2.35a. Percentage of health workers who reported being generally satisfied with their jobs (health centers and hospitals combined), by province and survey round

		Matched Panel 2019 (n=1071)	Matched Panel 2021 (n=1023)	Matched Panel 2024 (n=1142)		
		2019%	2021%	2024%	PP diff (2019 vs 2024)	p-value (2019 vs 2024)
Overall (6 provinces)		39.2	47	44.7	5.5	0.010***
Male		37.6	44	40.6	3	0.274
Female		41.5	52.1	49.9	8.4	0.010***
Eastern Congo						
	Sud Kivu	42	54.4	41.4	-0.6	0.876
	Tanganyika	59.8	53.9	60	0.2	0.974
Katanga						
	Haut Katanga	37.4	49.4	41.7	4.3	0.361
	Lualaba	46.2	63.6	58.3	12.1	0.059*
Kasai						
	Sankuru	34.6	20.1	28.5	-6.1	0.253
	Kasai Oriental	26.4	43	48.5	22.1	0.000***

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Table 2.35b. Percentage of health workers who reported being generally satisfied with their jobs (health centers and hospitals combined), by province and survey round

	Matched Panel 2021 (n=458)	Matched Panel 2024 (n=495)		
	%	%	PP diff (2021 vs 2024)	p-value (2021 vs 2024)
Overall (3 provinces)	44.3	53.9	9.6	0.003***
Male	43.2	49.5	6.3	0.135
Female	46	60.1	14.1	0.006***
Katanga				
Haut Lomami	51.8	53.3	1.5	0.818
Kasai				
Kasai Central	40.4	57.4	17	0.001***
Lomami	43.5	50.8	7.3	0.161

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Health Worker Training on Health Information Management

Health personnel working in HCs were asked whether had they received training on health information management systems (e.g., DHIS2, *Système National d'Information Sanitaire* [SNIS, National Health Information System], MAPEPI) in the past year. By the 2024 survey, there was a decline in the overall percentage of health workers across the six provinces that were included in all waves of the survey who reported receiving training on health information management, decreasing from 16.63 percent in 2019 to 10.51 percent in 2024, a statistically significant decline. This decrease was especially pronounced among male health workers, whose participation fell by 9.94 PPs. However, female health workers saw a slight non-significant increase in training participation. Kasai Oriental experienced significant declines in training participation, and Tanganyika, Lualaba, and Haut Katanga also saw decreases, although not statistically significant (Table 2.36a). For the three provinces included from 2021 to 2024, overall training participation significantly increased. A statistically significant increase was seen among male health workers, with Lomami and Kasai Central also showing a significant increase in reports of receiving training on health information management in the past year (Table 2.36b).

Table 2.36a. Health workers who received training on health information management (e.g., DHIS2, SNIS, MAPEPI) in the past year, by province and survey year

		Matched Panel 2019 (n=433)	Matched Panel 2021 (n=445)	Matched Panel 2024 (n=514)		
		%	%	%	PP diff (2019 vs 2024)	p-value (2019 vs 2024)
Overall (6 provinces)		16.63	11.69	10.51	-6.12	0.006***
Male		21.38	13.75	11.44	-9.94	0.001***
Female		8.28	7.79	9.13	0.85	0.775
Eastern Congo						
	Sud Kivu	11.19	13.22	10	-1.19	0.733
	Tanganyika	30.77	14.29	14.29	-16.48	0.145
Katanga						
	Haut Katanga	21.18	18.06	13.79	-7.39	0.202
	Lualaba	16.67	14.06	8.62	-8.05	0.238
Kasai						
	Sankuru	10.45	5.45	9.52	-0.93	0.876
	Kasai Oriental	21.18	6.12	9.24	-11.94	0.016**

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Table 2.36b. Health workers who received training on health information management (e.g., DHIS2, SNIS, MAPEPI) in the past year, by province and survey year

		Matched Panel 2021 (n=205)	Matched Panel 2024 (n=211)		
		%	%	PP diff (2021 vs 2024)	p-value (2021 vs 2024)
Overall (3 provinces)		5.85	13.74	7.89	0.007***
Male		6.87	18.98	12.11	0.003***
Female		4.05	4.05	0	---
Katanga					
	Haut Lomami	19.05	26.53	7.48	0.398
Kasai					
	Kasai Central	2.25	7.77	5.52	0.086*
	Lomami	2.7	13.56	10.86	0.018**

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Health workers were also asked if anyone had participated in a training on human resources management using the iHuman Resources Information System (iHRIS). There was a significant increase in the overall

percentage of health workers who reported receiving training on human resources management, rising from 6.5 percent in 2019 to 11.5 percent in 2024. Both male and female health workers saw significant increases in training participation, with females showing a larger increase of 6.1 PPs. Sud Kivu and Kasai Oriental reported significant increases. However, health facilities in other provinces saw non-significant decreases in training (Table 2.37a). For provinces included from 2021 to 2024, there was an overall significant increase in training participation. Significant increases were observed for male health workers, and in Kasai Central and Lomami (Table 2.37b).

Table 2.37a. Health workers who participated in a training on human resources management using the iHRIS, by province and survey year

	Matched Panel 2019 (n=964)	Matched Panel 2021 (n=882)	Matched Panel 2024 (n=948)		
	%	%	%	PP diff (2019 vs 2024)	p-value (2019 vs 2024)
Overall (6 provinces)	6.5	8.6	11.5	5	0.000***
Male	6.8	7.3	11	4.2	0.012**
Female	6.1	11	12.2	6.1	0.004***
Eastern Congo					
Sud Kivu	8.4	6.1	19.3	10.9	0.000***
Tanganyika	6.2	12.8	2.9	-3.3	0.273
Katanga					
Haut Katanga	11.4	14.3	10	-1.4	0.679
Lualaba	2.7	8.9	1.8	-0.9	0.629
Kasai					
Sankuru	4.7	5.7	2.9	-1.8	0.414
Kasai Oriental	2.4	8.3	19.4	17	0.000***

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Table 2.37b. Health workers who participated in a training on human resources management using the iHRIS, by province and survey year

	Matched Panel 2021 (n=437)	Matched Panel 2024 (n=460)		
	%	%	PP diff (2021 vs 2024)	p-value (2021 vs 2024)
Overall (3 provinces)	8.7	12.6	3.9	0.061*
Male	8.1	14.2	6.1	0.025**
Female	9.7	10.4	0.7	0.835
Katanga				
Haut Lomami	13	6.1	-6.9	0.068*
Kasai				
Kasai Central	10.1	19.4	9.3	0.018**
Lomami	5.1	11	5.9	0.044**
Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01				

A summary of key leadership and governance indicators is shown in Table 2.38. The table characterizes performance as of the 2024 survey, the direction of change between survey waves, and indicates whether the difference is statistically significant.

Table 2.38. Summary of leadership and governance indicators

Indicator	Performance (2024)	Direction (2019 vs 2024 unless indicated)
Capacity to plan, implement, and monitor services		
Health zone offices with a source of electricity	Mid-strong	↑*
Health zone offices with functioning electricity on the day of the survey	Strong	↓
Health zone offices with eight hours of electricity among those offices with functional electricity	Mid-strong	→
Health zone offices with cellular network availability	Mid-poor	↑
Health zone offices with Internet connectivity	Strong	↑*
Internet connectivity for at least eight hours per day at health zone offices	Mid-poor	↑*
Health zone offices' PICAL participation and scores		
Health zone offices' participation in PICAL assessments	Poor	↑ *
Health zone offices that received PICAL assessment scores	Strong	↑
Supervision		
Provincial health offices receiving higher-level supervision visits	Strong	N/A
Health zone offices receiving higher-level supervision visits	Strong	↑ *
Hospitals receiving higher-level supervision visits in the last calendar month	Mid-poor	↓*
Health centers receiving higher-level supervision visits in the last calendar month	Mid-poor	↓*
Health zone offices' communication with CODESAs		
Health zone offices in communication with CODESAs at least monthly	Strong	↑

Indicator	Performance (2024)	Direction (2019 vs 2024 unless indicated)
Health facilities that participated in orientation of CODESA members (2021 vs 2024)	Strong	↑ *
Health facilities' report of high CODESA involvement in operations/management decisions	Mid-strong	↑ *
Percentage of health facilities that were aware of the community scorecard program	Poor	↑ *
Provincial health office attendance at technical meetings and communications frequency with other health offices		
Provincial health offices' attendance at technical meetings	Strong	→
Health zone offices' communication with other health zone offices	Mid-poor	↓
Health zone offices' participation in COGE provincial meetings	Strong	↑
Health zone management of *mutuelles*		
Health zone offices tracking of *mutuelles*	Mid-strong	↓
Health facilities seeking permission from health zone offices for service fee reductions	Poor	↑
Health zone office supervision of *mutuelles*	Strong	↑ *
Timing of health office reporting their most recent MAPEPI cases		
Provincial health office reporting of MAPEPI cases within 24 hours	Mid-strong	↑
Health zone offices' report of most recent MAPEPI case within 24 hours	Strong	↑
Strengthened capacity of CSOs and community structures to provide health system oversight		
CODESA implementation of community scorecard activities in the past 24 months (2021 vs 2024)	Mid-poor	↓*
CODESA access to patient feedback and/or information about facility malfeasance (2021 vs 2024)	Mid-strong	↑
CODESA reactions to patient feedback and/or information about facility malfeasance (2021 vs 2024)	Strong	↓
Health worker satisfaction		
Health workers who reported being generally satisfied with their job	Mid-poor	↑ *
Health worker training on health information management		
Health workers who received training on health information management in the past year	Poor	↓*
Health workers who participated in a training on human resources management using the iHRIS	Poor	↑*

Notes: Strong= 75%–100% of respondents; Mid-Strong= 50%–74% of respondents; Mid-Poor=25%–49% of respondents; Poor=0%–24% of respondents overall in 2024. Arrows indicate the direction of change between 2019 and 2024 in the matched panel. * indicates that the change was statistically significant at $p<0.1$.

Service Quality

Service Readiness

Preventive Services

HCs were assessed for whether they offered each of the MOH's minimum package of preventive services. The percentage offering all nine preventive services was significantly higher in 2024 compared with 2019, although fewer than half of the HCs met this standard (Table 3.1a). The change was driven by higher prevalences of FP services and zinc supplementation in 2024.

Overall, there was no significant difference in offering all preventive services between 2021 and 2024 (Table 3.1b). FP services were significantly more prevalent in 2024.

Table 3.1a. Health centers that offered the MOH's minimum package of preventive services, by survey round

	Matched panel (n=296)				
	2019%	2021%	2024%	PP diff (2019 vs 2024)	p-value (2019 vs 2024)
Prenatal consultation	96.6	97.0	98.0	1.4	0.30
Malaria intermittent preventive therapy (IPT)	93.9	93.2	88.2	-5.7	0.02***
Postnatal consultation	89.4	94.2	92.9	3.5	0.14
FP	78.5	86.1	94.3	15.8	<0.01***
Vaccination	95.6	94.9	98.0	2.4	0.10
Growth monitoring	88.7	90.5	89.5	0.8	0.76
Zinc supplementation	38.2	71.9	84.5	46.2	<0.01***
Mebendazole supplementation	74.1	69.8	69.9	-4.1	0.27
All select preventive services	25.3	42.7	47.0	21.7	<0.01***

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Table 3.1b. Health centers that offered the MOH's minimum package of preventive services, by survey round

	Matched panel (n=158)			
	2021%	2024%	PP diff (2021 vs 2024)	p-value (2021 vs 224)
Prenatal consultation	97.5	98.1	0.6	0.70
Malaria IPT	93.0	91.8	-1.3	0.67
Postnatal consultation	95.6	96.2	0.6	0.78
FP	88.6	96.8	8.2	<0.01***
Vaccination	86.7	87.3	0.6	0.87
Growth monitoring	84.8	90.5	5.7	0.12
Zinc supplementation	91.8	86.7	-5.1	0.15
Mebendazole supplementation	81.7	75.3	-6.3	0.17
All select preventive services	45.6	43.7	-1.9	0.73

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

After stratifying by province, the presence of the minimum package of preventive services was significantly higher in 2024 compared with 2019 in three provinces: Sud Kivu, Sankuru, and Kasai Oriental (Table 3.2a). No significant differences were observed in the 2021/2024 panel (Table 3.2b).

Table 3.2a. Health centers that offered all select MOH minimum package of preventive services, by province and survey round

		Matched panel (n=296)				
		2019%	2021%	2024%	PP diff (2019 vs 2024)	p-value (2019 vs 2024)
Overall (6 provinces)		25.3	42.7	47.0	21.7	<0.01***
Eastern Congo	Sud Kivu	31.0	50.0	70.1	39.1	<0.01***
	Tanganyika	19.2	53.9	26.9	7.7	0.51
Katanga	Haut Katanga	31.6	50.0	36.2	4.6	0.60
	Lualaba	45.5	51.4	51.4	6.0	0.62
Kasai	Sankuru	2.5	10.0	27.5	25.0	<0.01***
	Kasai Oriental	16.0	36.0	42.0	26.0	<0.01***

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Table 3.2b. Health centers that offered all select MOH minimum package of preventive services, by province and survey round

		Matched panel (n=158)			
		2021%	2024%	PP diff (2021 vs 2024)	p-value (2021-2024)
Overall (3 provinces)		45.6	43.7	-1.9	0.73
Katanga	Haut Lomami	36.1	52.8	16.7	0.16
Kasai	Kasai Central	52.7	47.3	-5.4	0.51
	Lomami	41.7	31.3	-10.4	0.29

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

The percentage of HCs with vaccines in stock was significantly higher in 2024 compared with 2019 for all nine vaccines assessed (Table 3.3a). Prevalence ranged from 54.4 percent (BCG) to 73.3 percent (measles and pneumococcal conjugate vaccine-13 [PCV 13]) in 2024. The largest 2019-to-2024 difference was the rotavirus vaccine, which was 65.5 PPs higher in 2024.

Table 3.3a. Percentage of health centers with vaccines in stock, by survey round

	Matched panel (n=296)				
	2019%	2021%	2024%	PP diff (2019 vs 2024)	p-value (2019 vs 2024)
BCG	40.3	29.8	54.4	14.1	<0.01***
Pentavalent	60.4	60.7	71.6	11.2	<0.01***
Oral polio vaccine (OPV)	59.7	59.7	68.9	9.2	0.02**
Inactive poliovirus vaccine (IPV)	60.4	61.0	72.3	11.9	<0.01***
Measles	58.4	56.3	73.3	15.0	<0.01***
Yellow fever	57.3	57.6	69.6	12.3	<0.01***
PCV 13 (pneumonia)	62.1	61.4	73.3	11.2	<0.01***
Rotavirus	7.5	61.4	73.0	65.5	<0.01***
Tetanus-diphtheria	45.7	60.0	70.6	24.9	<0.01***
All vaccines	3.1	24.8	40.5	37.5	<0.01***

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

In the 2021/2024 panel, the prevalence of BCG and measles vaccines was significantly higher in 2024 (Table 3.3b).

Table 3.3b. Percentage of health centers with vaccines in stock, by survey round

	Matched panel (n=158)			
	2021%	2024%	PP diff (2021 vs 2024)	p-value (2021 vs 224)
BCG	36.1	48.7	12.7	0.02**
Pentavalent	57.0	60.8	3.8	0.49
OPV (polio)	55.1	58.2	3.2	0.57
IPV (polio)	53.2	60.1	7.0	0.21
Measles	50.6	60.1	9.5	0.09*
Yellow fever	53.8	58.9	5.1	0.36
PCV 13 (pneumonia)	54.4	61.4	7.0	0.21
Rotavirus	53.2	57.6	4.4	0.43
Tetanus-diphtheria	55.7	61.4	5.7	0.30
All vaccines	31.0	38.0	7.0	0.19

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Respondents were asked about the locations at which the HC provided immunizations (Tables 3.4a and 3.4b). The most commonly mentioned location for all three types (birth doses, infant vaccines, and adult doses) was the facility only. Very few facilities offered vaccines at both the facility and through outreach at a fixed point.

The locations of adult vaccines changed significantly between 2019 and 2024, with the percentage of facilities not offering these vaccines decreasing. It should be noted that the high number of facilities reporting that they did not offer vaccines may reflect confusion about the question because some facilities shared refrigerators with neighboring facilities.

Table 3.4a. Percentage of health centers that provided the following immunizations at the facility only, through outreach at a fixed post, or both (birth doses, infant vaccines, adolescent/adult vaccines)

	Matched panel (n=296)				
	2019%	**2021%**	**2024%**	**PP diff (2019 vs 2024)**	**p-value (2019 vs 2024)**
Birth doses					0.24
Facility only	68.3	75.6	73.3	5.1	
Outreach at a fixed post only	26.6	19.3	23.7	-3.0	
Both	0.0	0.0	0.3	0.3	
Not offered	5.1	5.1	2.7	-2.4	
Infant vaccines					0.38
Facility only	82.6	83.1	81.8	-0.8	
Outreach at a fixed post only	13.0	11.9	15.5	2.6	
Both	0.0	0.0	0.0	0.0	
Not offered	4.4	5.1	2.7	-1.7	
Adolescent/adult vaccines					
Facility only	25.6	28.8	42.2	16.6	<0.01***
Outreach at a fixed post only	22.9	26.8	30.4	7.5	
Both	1.4	1.4	1.0	-0.4	
Not offered	50.2	43.1	26.4	-23.8	

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Table 3.4b. Percentage of health centers that provided the following immunizations at the facility only, through outreach at a fixed post, or both (birth doses, infant vaccines, adolescent/adult vaccines)

	Matched panel (n=158)			
	2021%	2024%	PP diff (2021 vs 2024)	p-value (2021 vs 224)
Birth doses				0.86
Facility only	70.9	73.4	2.5	
Outreach at a fixed post only	14.6	12.7	-1.9	
Both	0.0	0.0	0.0	
Not offered	14.6	13.9	-0.6	
Infant vaccines				0.29
Facility only	72.8	78.5	5.7	
Outreach at a fixed post only	10.1	6.3	-3.8	
Both	1.3	0.0	-1.3	
Not offered	15.8	15.2	-0.6	
Adolescent/adult vaccines				0.05**
Facility only	38.6	47.5	8.9	
Outreach at a fixed post only	15.2	21.5	6.3	
Both	1.9	1.3	-0.6	
Not offered	44.3	29.8	-14.6	

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Most of the surveyed HCs distributed insecticide-treated nets to patients. By 2024, more than 97 percent of the HCs in the 2019/2024 panel did so, a significant increase from 2019 (Table 3.5a). Similarly high levels were found in the 2021/2024 panel, with no significant changes detected (Table 3.5b).

Table 3.5a. Percentage of health centers that distributed insecticide-treated nets to patients on the day of the survey

	Matched panel (n=296)				
	2019%	2021%	2024%	PP diff (2019 vs 2024)	p-value (2019 vs 2024)
Overall (6 provinces)	86.4	96.6	97.3	11.0	<0.01***
Eastern Congo					
Sud Kivu	92.0	90.7	93.1	1.1	0.77
Tanganyika	84.6	96.2	100.0	15.4	0.04**
Katanga					
Haut Katanga	75.4	98.3	96.6	21.1	<0.01***
Lualaba	100.0	100.0	100.0	0.0	1.00
Kasai					
Sankuru	97.5	100.0	100.0	2.5	0.31
Kasai Oriental	72.0	100.0	100.0	28.0	<0.01***

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Table 3.5b. Percentage of health centers that distributed insecticide-treated nets to patients on the day of the survey

	Matched panel (n=158)			
	2021%	2024%	PP diff (2021 vs 2024)	p-value (2021-2024)
Overall (3 provinces)	95.6	98.1	2.5	0.20
Katanga				
Haut Lomami	97.2	100.0	0.31	0.31
Kasai				
Kasai Central	93.2	96.0	0.47	0.47
Lomami	97.9	100.0	0.32	0.32

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Although the percentage of HCs that offered all seven services for pregnant women was significantly higher in 2024 compared with 2019, the overall percentage of facilities remained low at 16.2 percent (Table 3.6a). The percentage offering IPT for malaria decreased significantly, whereas folate supplementation and FP counseling increased. The least common services were counseling on FP (57.1%) and nutrition planning (30.7%).

In the 2021/2024 panel, the percentage of HCs offering all services for pregnant women was significantly higher in 2024, at 42.4 percent (Table 3.6b). There was a significant decrease in iron supplementation between 2021 and 2024 in that panel, although the 2024 prevalence was similar between the two panels, at approximately 77 percent.

Table 3.6a. Percentage of health centers that offered all seven services for pregnant women on the day of the survey, by type of service

	Matched panel (n=296)				
	2019%	2021%	2024%	PP diff (2019 vs 2024)	p-value (2019 vs 2024)
Tetanus vaccine	74.1	71.9	69.3	-4.8	0.20
Iron supplements	70.3	67.8	76.7	6.4	0.08*
Folate supplements	53.6	58.6	65.2	11.6	<0.01***
IPT for malaria	93.9	93.2	88.2	-5.7	0.02**
Anthelminthics/deworming treatment	62.8	59.0	60.8	-2.0	0.62
Counseling on FP	25.6	25.4	57.1	31.5	<0.01***
Nutrition planning	27.3	19.0	30.7	3.4	0.36
All services	8.5	8.8	16.2	7.7	<0.01***

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Table 3.6b. Percentage of health centers that offered all seven services for pregnant women on the day of the survey, by type of service

	Matched panel (n=158)			
	2021%	2024%	PP diff (2021 vs 2024)	p-value (2021 vs 224)
Tetanus vaccine	81.0	85.4	4.4	0.29
Iron supplements	89.9	77.2	-12.7	<0.01***
Folate supplements	79.8	82.9	3.2	0.47
IpT for malaria	93.0	91.8	-1.3	0.67
Anthelminthics/deworming treatment	65.8	75.3	9.5	0.06*
Counseling on FP	58.9	70.9	12.0	0.03**
Nutrition planning	56.3	65.8	9.5	0.08*
All services	32.3	42.4	10.1	0.06*

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

The prevalence of nine postpartum services at HCs was assessed. A very small percentage of HCs offered all nine services in 2024 (7.8%) (Table 3.7a). There were significant increases between 2019 and 2024 in three services: FP counseling, prevention of mother-to-child transmission (PMTCT) counseling, and counseling on mother and child hygiene. However, the prevalence of three services remained particularly low: growth monitoring and promotion, PMTCT counseling, and dietary counseling for breastfeeding.

Postpartum services were generally more prevalent in the 2021/2024 panel, with the percentage of HCs offering all nine services increasing from 24.7 percent to 36.7 percent between 2021 and 2024, a statistically significant change (Table 3.7b).

Table 3.7a. Percentage of health centers that offered all nine postpartum services, by type of service

	Matched panel (n=296)				
	2019%	2021%	2024%	PP diff (2019 vs 2024)	p-value (2019 vs 2024)
Maternal examination	58.7	58.3	64.9	6.2	0.12
Breastfeeding counseling	60.8	64.1	64.5	3.8	0.34
Newborn examination	66.9	64.8	68.6	1.7	0.66
Growth monitoring and promotion	25.9	25.4	31.4	5.5	0.14
Vaccination counseling	53.9	44.8	54.4	0.5	0.91
FP counseling	33.8	32.2	52.4	18.6	<0.01***
PMTCT counseling	15.7	19.0	29.1	13.4	<0.01***
Dietary counseling for breastfeeding	28.0	20.3	27.0	-1.0	0.79
Counseling on mother and child hygiene	36.9	27.5	50.3	13.5	<0.01***
All services	5.1	2.7	7.8	2.7	0.19

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Table 3.7b. Percentage of health centers that offered all nine postpartum services, by type of service

	Matched panel (n=158)			
	2021%	2024%	PP diff (2021 vs 2024)	p-value (2021 vs 224)
Maternal examination	70.9	72.8	1.9	0.71
Breastfeeding counseling	74.7	88.6	13.9	<0.01***
Newborn examination	80.4	84.8	4.4	0.30
Growth monitoring and promotion	54.4	67.1	12.7	0.02**
Vaccination counseling	74.1	81.0	7.0	0.14
FP counseling	67.7	75.3	7.6	0.14
PMTCT counseling	46.8	53.2	6.3	0.26
Dietary counseling for breastfeeding	57.6	69.6	12.0	0.03**
Counseling on mother and child hygiene	65.2	76.0	10.8	0.04**
All services	24.7	36.7	12.0	0.02**

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Curative and Laboratory Services

HCs were assessed for whether they offered each of the MOH's minimum package of curative services. The percentage offering all six preventive services was significantly higher in 2024 compared with 2019, although fewer than three percent of HCs met this standard (Table 3.8a). The change was driven by higher prevalences of HIV treatment and normal deliveries in 2024.

Overall, there was no significant difference in offering all curative services between 2021 and 2024 (Table 3.8b).

Table 3.8a. Health centers that offered select MOH minimum package of curative services, by survey round

	Matched panel (n=296)				
	2019%	2021%	2024%	PP diff (2019 vs 2024)	p-value (2019 vs 2024)
HIV testing	45.1	44.9	43.2	-1.8	0.66
HIV treatment	23.6	33.1	33.8	10.2	<0.01***
TB testing	19.8	21.3	23.7	3.9	0.26
TB treatment	39.9	43.6	42.6	2.6	0.52
Minor surgery	7.5	9.5	9.8	2.3	0.32
Normal deliveries	91.5	94.9	95.6	4.1	0.04**
All curative services	0.7	0.7	2.7	2.0	0.06*

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Table 3.8b. Health centers that offered select MOH minimum package of curative services, by survey round

	Matched panel (n=158)			
	2021%	2024%	PP diff (2021 vs 2024)	p-value (2021 vs 224)
HIV testing	39.2	32.3	-7.0	0.20
HIV treatment	36.7	34.2	-2.5	0.64
TB testing	40.5	37.3	-3.2	0.56
TB treatment	50.0	54.4	4.4	0.43
Minor surgery	26.6	22.8	-3.8	0.43
Normal deliveries	94.9	96.8	1.9	0.40
All curative services	11.4	13.9	2.5	0.50

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

When stratifying by province, the only significant increases that were observed occurred between 2019 and 2024 in Sud Kivu. No other significant differences were observed (Tables 3.9a and 3.9b).

Table 3.9a. Health centers that offered all curative services, by province and survey round

		Matched panel (n=296)				
		2019%	2021%	2024%	PP diff (2019 vs 2024)	p-value (2019 vs 2024)
Overall (6 provinces)		0.7	0.7	2.7	2.0	0.06*
Eastern Congo						
	Sud Kivu	0.0	0.0	3.5	3.5	0.08*
	Tanganyika	0.0	0.0	3.9	3.9	0.31
Katanga						
	Haut Katanga	1.8	3.5	3.5	1.7	0.57
	Lualaba	0.0	0.0	0.0	0.0	1.00
Kasai						
	Sankuru	0.0	0.0	0.0	0.0	1.00
	Kasai Oriental	2.0	0.0	4.0	2.0	0.56

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Table 3.9b. Health centers that offered all curative services, by province and survey round

		Matched panel (n=158)			
		2021%	2024%	PP diff (2021 vs 2024)	p-value (2021-2024)
Overall (3 provinces)		11.4	13.9	2.5	0.50
Katanga					
	Haut Lomami	8.3	16.7	8.3	0.29
Kasai					
	Kasai Central	18.9	16.2	-2.7	0.67
	Lomami	2.1	8.3	6.3	0.17

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Hospitals' capacity to conduct specific laboratory tests was also assessed. There were very few significant differences between 2019 and 2021; only the prevalence of blood glucose testing significantly increased (Table 3.10a). The prevalence of all tests was above 80 percent in 2024, with the exception of Gram stain, which was offered at only 56 percent of hospitals.

There were no significant differences detected in the 2021/2024 panel, and a similar pattern was observed, with most tests having a high prevalence, with the exception of Gram stain (Table 3.10b).

Table 3.10a. Hospitals with capacity to conduct specific laboratory tests on the day of the survey (MOH complementary package of services), by survey round

	Matched panel (n=116)				
	2019%	2021%	2024%	PP diff (2019 vs 2024)	p-value (2019 vs 2024)
Parasitology					
Malaria microscopy	91.4	94.0	92.2	0.9	0.81
Stool direct microscopic exam	95.7	95.7	95.7	0.0	1.00
Hematology					
Hemoglobin testing	94.8	96.6	94.8	0.0	1.00
White blood cell count	81.9	83.8	86.2	4.3	0.37
Leukocyte formula	78.5	82.9	82.8	4.3	0.41
Sedimentation rate	85.3	88.9	85.3	0.0	1.00
Blood type and crossmatch	95.7	95.7	94.8	-0.9	0.76
Bacteriology					
Ziehl stain	90.5	90.6	91.4	0.9	0.82
Gram stain	57.8	53.9	56.0	-1.7	0.79
Urine analysis	94.8	94.9	94.8	0.0	1.00
Biochemical					
Blood glucose	81.9	90.6	90.5	8.6	0.06*
HIV testing	95.7	97.4	95.7	0.0	1.00
Syphilis testing	90.5	94.9	91.4	0.9	0.82
Pregnancy testing	94.0	95.7	94.8	0.9	0.78
Hepatitis testing	88.8	94.9	87.9	-0.9	0.84

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Table 3.10b. Hospitals with capacity to conduct specific laboratory tests on the day of the survey (MOH complementary package of services), by survey round

	Matched panel (n=24)			
	2021%	2024%	PP diff (2021 vs 2024)	p-value (2019 vs 2024)
Parasitology				
Malaria microscopy	95.8	100.0	4.2	0.31
Stool direct microscopic exam	100.0	100.0	0.0	1.00
Hematology				
Hemoglobin testing	100.0	100.0	0.0	1.00
White blood cell count	83.3	91.7	8.3	0.38
Leukocyte formula	79.2	87.5	8.3	0.44
Sedimentation rate	87.5	95.8	8.3	0.30
Blood type and crossmatch	100.0	100.0	0.0	1.00
Bacteriology				
Ziehl stain	95.8	100.0	4.2	0.31
Gram stain	54.2	41.7	-12.5	0.39
Urine analysis	95.8	100.0	4.2	0.31
Biochemical				
Blood glucose	79.2	87.5	8.3	0.44
HIV testing	100.0	95.8	-4.2	0.31
Syphilis testing	95.8	95.8	0.0	1.00
Pregnancy testing	95.8	100.0	4.2	0.31
Hepatitis testing	100.0	100.0	0.0	1.00

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Complementary Services

Nearly all HCs offered malaria screening (Tables 3.11a and 3.11b). There were small but not statistically significant increases in the percentage of HCs offering laboratory confirmed diagnosis.

Table 3.11a. Percentage of health centers that offered malaria screening on the day of the survey, by screening type

	Matched panel (n=296)				
	2019%	2021%	2024%	PP diff (2019 vs 2024)	p-value (2019 vs 2024)
Rapid test	98.0	98.7	99.0	1.0	0.31
Laboratory confirmed	22.2	23.7	23.7	1.5	0.67
No malaria testing	2.1	1.4	1.0	-1.0	0.31

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Table 3.11b. Percentage of health centers that offered malaria screening on the day of the survey, by screening type

	Matched panel (n=158)			
	2021%	2024%	PP diff (2021 vs 2024)	p-value (2021 vs 224)
Rapid test	98.7	98.7	0.0	1.00
Laboratory confirmed	27.9	31.0	3.2	0.54
No malaria testing	0.6	0.6	0.0	1.00

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

The percentage of HCs that offered TB screening was not significantly different in the 2019/2024 panel or the 2021/2024 panel (Tables 3.12a and 3.12b). The prevalence of screening was relatively low in 2024 (23.6% in the 2019/2024 panel and 37.3% in the 2021/2024 panel). The most common screening was Ziehl Neelsen.

Table 3.12a. Percentage of health centers that offered TB screening on the day of the survey, by screening type

	Matched panel (n=296)				
	2019%	2021%	2024%	PP diff (2019 vs 2024)	p-value (2019 vs 2024)
Ziehl Neelssen	19.8	21.0	23.0	3.2	0.35
Gene Xpert	1.0	1.7	2.0	1.0	0.32
Skin test	0.0	0.7	1.0	1.0	0.08*
Chest X-ray	0.7	1.7	0.7	0.0	1.00
Culture Lowenstein	0.0	0.0	0.0	0.0	NA
Any TB screening	19.8	21.3	23.6	3.9	0.26

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Table 3.12b. Percentage of health centers that offered TB screening on the day of the survey, by screening type

	Matched panel (n=158)			
	2021%	2024%	PP diff (2021 vs 2024)	p-value (2021 vs 224)
Ziehl Neelssen	40.5	36.7	-3.8	0.49
Gene Xpert	1.3	5.1	3.8	0.05*
Skin test	0.0	1.9	1.9	0.08*
Chest X-ray	3.8	2.5	-1.3	0.52
Culture Lowenstein	0.0	1.9	1.9	0.08*
Any TB screening	40.5	37.3	-3.2	0.56

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

The percentage of HCs that offered any treatment for TB was not significantly different in the 2019/2024 or the 2021/2024 panel (Tables 3.13a and 3.13b). There were no significant changes in the percentage providing directly observed or not directly observed TB treatment.

Table 3.13a. Health centers that offered TB treatment, by type of treatment and survey round

	Matched panel (n=296)				
	2019%	2021%	2024%	PP diff (2019 vs 2024)	p-value (2019 vs 2024)
Any treatment	39.9	43.7	42.6	2.6	0.52
Directly observed	32.4	38.3	37.2	4.7	0.23
Not directly observed	19.8	24.4	17.2	-2.6	0.42

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Table 3.13b. Health centers that offered TB treatment, by type of treatment and survey round

	Matched panel (n=158)			
	2021%	2024%	PP diff (2021 vs 2024)	p-value (2021 vs 224)
Any treatment	50.0	54.4	4.4	0.43
Directly observed	48.1	50.0	1.9	0.74
Not directly observed	12.0	15.2	3.2	0.41

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

The percentage of HCs that offered a long-acting or permanent method of FP increased significantly between 2019 and 2024 overall and for all provinces assessed except Lualaba (Table 3.14a). The 2021/24 panel saw significant increases overall and in Kasai Central and Lomami (Table 3.14b).

Table 3.14a. Health centers that offered a long-acting or permanent method of FP, by province and survey round

		Matched panel (n=296)				
		2019%	2021%	2024%	PP diff (2019 vs 2024)	p-value (2019 vs 2024)
Overall (6 provinces)		56.3	77.7	86.7	30.5	<0.01***
Eastern Congo						
	Sud Kivu	66.7	77.1	92.9	26.3	<0.01***
	Tanganyika	44.0	76.9	92.3	48.3	<0.01***
Katanga						
	Haut Katanga	56.1	79.3	79.3	23.2	<0.01***
	Lualaba	87.9	94.3	80.0	-7.9	0.38
Kasai						
	Sankuru	56.4	75.0	82.5	26.1	0.01**
	Kasai Oriental	24.0	68.0	90.0	66.0	<0.01***

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Table 3.14b. Health centers that offered a long-acting or permanent method of FP, by province and survey round

		Matched panel (n=158)			
		2021%	2024%	PP diff (2021 vs 2024)	p-value (2021-2024)
Overall (3 provinces)		78.3	86.1	7.7	0.07*
Katanga					
	Haut Lomami	77.1	66.7	-10.5	0.33
Kasai					
	Kasai Central	89.2	100.0	10.8	<0.01***
	Lomami	62.5	79.2	16.7	0.07*

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

The percentage of hospitals that offered a long-acting or permanent method of FP increased significantly between 2019 and 2024 overall and in Kasai Oriental (Table 3.15a). Notably, 100 percent of hospitals in Sud Kivu, Sankuru, Haut Lomami, and Kasai Central offered these services in 2024 (Tables 3.15a and 3.15b).

Table 3.15a. Hospitals offering a long-acting or permanent method of FP, by province and survey round

		Matched panel (n=116)				
		2019%	2021%	2024%	PP diff (2019 vs 2024)	p-value (2019 vs 2024)
Overall (6 provinces)		83.3	91.4	94.0	10.6	0.01**
Eastern Congo						
	Sud Kivu	93.3	100.0	100.0	6.7	0.14
	Tanganyika	80.0	90.0	90.0	10.0	0.53
Katanga						
	Haut Katanga	79.3	92.9	92.6	13.3	0.16
	Lualaba	81.8	75.0	83.3	1.5	0.92
Kasai						
	Sankuru	100.0	100.0	100.0	0.0	1.00
	Kasai Oriental	61.1	79.0	89.5	28.4	0.04**

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Table 3.15b. Hospitals offering a long-acting or permanent method of FP, by province and survey round

		Matched panel (n=24)			
		2021%	2024%	PP diff (2021 vs 2024)	p-value (2021-2024)
Overall (3 provinces)		83.3	95.7	12.3	0.17
Katanga					
	Haut Lomami	100.0	100.0	0.0	1.00
Kasai					
	Kasai Central	75.0	100.0	25.0	0.16
	Lomami	71.4	85.7	14.3	0.52

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

The percentage of HCs with youth-specific FP services increased significantly overall between 2019 and 2024 (Table 3.16a). This was driven by significant increases in Sud Kivu, Haut Katanga, Sankuru, and Kasai Oriental. In the 2021/24 panel, a significant decrease was observed in Haut Lomami, whereas Kasai Central saw a significant increase (Table 3.16b).

Table 3.16a. Health centers with FP information and resources specific to youth, by province and survey round

		Matched panel (n=296)				
		2019%	2021%	2024%	PP diff (2019 vs 2024)	p-value (2019 vs 2024)
Overall (6 provinces)		20.5	28.1	39.1	18.6	<0.01***
Eastern Congo						
	Sud Kivu	23.8	22.9	42.4	18.5	0.01**
	Tanganyika	16.0	19.2	34.6	18.6	0.13
Katanga						
	Haut Katanga	12.3	22.4	32.8	20.5	<0.01***
	Lualaba	21.2	28.6	20.0	-1.2	0.90
Kasai						
	Sankuru	18.0	25.0	40.0	22.1	0.03**
	Kasai Oriental	28.0	50.0	56.0	28.0	<0.01***

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Table 3.16b. Health centers with FP information and resources specific to youth, by province and survey round

		Matched panel (n=158)			
		2021%	2024%	PP diff (2021 vs 2024)	p-value (2021-2024)
Overall (3 provinces)		49.0	55.1	6.0	0.29
Katanga					
	Haut Lomami	45.7	22.2	-23.5	0.04**
Kasai					
	Kasai Central	58.1	83.8	25.7	<0.01***
	Lomami	37.5	35.4	-2.1	0.83

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

No changes in the prevalence of youth-specific FP information were noted for hospitals, with the exception of a significant increase in Sud Kivu between 2019 and 2024 (Tables 3.17a and 3.17b).

Table 3.17a. Hospitals with FP information and resources specific to youth, by province and survey round

		Matched panel (n=116)				
		2019%	2021%	2024%	PP diff (2019 vs 2024)	p-value (2019 vs 2024)
Overall (6 provinces)		35.1	40.5	42.2	7.2	0.27
Eastern Congo						
	Sud Kivu	33.3	40.0	54.8	21.5	0.09*
	Tanganyika	10.0	50.0	10.0	0.0	1.00
Katanga						
	Haut Katanga	44.8	39.3	40.7	-4.1	0.76
	Lualaba	18.2	41.7	25.0	6.8	0.69
Kasai						
	Sankuru	43.8	43.8	43.8	0.0	1.00
	Kasai Oriental	38.9	31.6	47.4	8.5	0.60

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Table 3.17b. Hospitals with FP information and resources specific to youth, by province and survey round

		Matched panel (n=24)			
		2021%	2024%	PP diff (2021 vs 2024)	p-value (2021-2024)
Overall (3 provinces)		33.3	47.8	14.5	0.31
Katanga					
	Haut Lomami	33.3	55.6	22.2	0.34
Kasai					
	Kasai Central	37.5	71.4	33.9	0.19
	Lomami	28.6	14.3	-14.3	0.52

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

The percentage of HCs offering a package of comprehensive sexual and gender-based violence (SGBV) services increased significantly overall between 2019 and 2024 (Table 3.18a). This was driven by increases in Sud Kivu, Sankuru, and Kasai Oriental. No significant changes were observed in the 2021/24 panel (Table 3.18b).

Table 3.18a. Health centers offering a package of comprehensive SGBV services, by province and survey round

		Matched panel (n=296)				
		2019%	2021%	2024%	PP diff (2019 vs 2024)	p-value (2019 vs 2024)
Overall (6 provinces)		29.5	40.8	44.6	15.1	<0.01***
Eastern Congo						
	Sud Kivu	45.2	55.4	60.0	14.8	0.06*
	Tanganyika	32.0	34.6	38.5	6.5	0.63
Katanga						
	Haut Katanga	29.8	27.6	39.7	9.8	0.27
	Lualaba	12.1	20.0	14.3	2.2	0.79
Kasai						
	Sankuru	10.3	42.5	50.0	39.7	<0.01***
	Kasai Oriental	28.0	48.0	44.0	16.0	0.10*

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Table 3.18b. Health centers offering a package of comprehensive SGBV services, by province and survey round

		Matched panel (n=158)			
		2021%	2024%	PP diff (2021 vs 2024)	p-value (2021-2024)
Overall (3 provinces)		51.6	56.3	4.7	0.40
Katanga					
	Haut Lomami	40.0	33.3	-6.7	0.56
Kasai					
	Kasai Central	67.6	74.3	6.8	0.37
	Lomami	35.4	45.8	10.4	0.30

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

No changes in the prevalence of comprehensive SGBV services were noted for hospitals, with the exception of a significant increase in Tanganyika between 2019 and 2024 (Tables 3.19a and 3.19b).

Table 3.19a. Hospitals offering a package of comprehensive SGBV services, by province and survey round

		Matched panel (n=116)				
		2019%	2021%	2024%	PP diff (2019 vs 2024)	p-value (2019 vs 2024)
Overall (6 provinces)		76.3	81.0	78.5	2.1	0.70
Eastern Congo						
	Sud Kivu	83.3	80.0	87.1	3.8	0.68
	Tanganyika	40.0	70.0	80.0	40.0	0.07*
Katanga						
	Haut Katanga	79.3	82.1	74.1	-5.2	0.64
	Lualaba	63.6	83.3	58.3	-5.3	0.80
Kasai						
	Sankuru	68.8	75.0	75.0	6.3	0.69
	Kasai Oriental	94.4	89.5	89.5	-5.0	0.58

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Table 3.19b. Hospitals offering a package of comprehensive SGBV services, by province and survey round

		Matched panel (n=24)			
		2021%	2024%	PP diff (2021 vs 2024)	p-value (2021-2024)
Overall (3 provinces)		75.0	73.9	-1.1	0.93
Katanga					
	Haut Lomami	66.7	55.6	-11.1	0.63
Kasai					
	Kasai Central	87.5	71.4	-16.1	0.44
	Lomami	71.4	100.0	28.6	0.13

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Infrastructure

The percentage of HCs with functional electricity on the day of the survey in the 2019/2024 panel was 19.3 percent (Table 3.20a) and 35.4 percent in the 2021/2024 panel (Table 3.20b). There was substantial variation among the provinces; approximately 4 percent of HCs in Tanganyika and Kasai Oriental had functional electricity in 2024 compared with 44.6 percent in Kasai Central. Significant increases were observed in Sud Kivu and Sankuru.

Table 3.20a. Health centers with functional electricity on the day of the survey, by province and survey round

		Matched panel (n=296)				
		2019%	2021%	2024%	PP diff (2019 vs 2024)	p-value (2019 vs 2024)
Overall (6 provinces)		15.2	14.2	19.3	4.2	0.18
Eastern Congo						
	Sud Kivu	18.6	10.5	31.4	12.8	0.05*
	Tanganyika	0.0	7.7	3.9	3.9	0.31
Katanga						
	Haut Katanga	36.8	37.9	37.9	1.1	0.90
	Lualaba	18.2	20.0	5.7	-12.5	0.11
Kasai						
	Sankuru	0.0	0.0	7.5	7.5	0.08*
	Kasai Oriental	2.0	4.0	4.0	2.0	0.57

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Table 3.20b. Health centers with functional electricity on the day of the survey, by province and survey round

		Matched panel (n=158)			
		2021%	2024%	PP diff (2021 vs 2024)	p-value (2021-2024)
Overall (3 provinces)		28.5	35.4	7.0	0.19
Katanga					
	Haut Lomami	33.3	36.1	2.8	0.80
Kasai					
	Kasai Central	33.8	44.6	10.8	0.18
	Lomami	16.7	20.8	4.2	0.60

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

The percentage of hospitals with functional electricity on the day of the survey in the 2019/2024 panel was 43.1 percent (Table 3.21a) and 58.3 percent in the 2021/2024 panel (Table 3.21b). Similar to the HCs, there was substantial variation among the provinces: 10 percent of hospitals in Tanganyika had functional electricity in 2024 compared with 77.8 percent in Haut Katanga and 75 percent Kasai Central. Significant increases were observed in Sud Kivu and Haut Katanga.

Table 3.21a. Hospitals with functional electricity on the day of the survey, by province and survey round

		Matched panel (n=116)				
		2019%	2021%	2024%	PP diff (2019 vs 2024)	p-value (2019 vs 2024)
Overall (6 provinces)		36.3	48.3	43.1	6.8	0.29
Eastern Congo						
	Sud Kivu	23.3	43.3	51.6	28.3	0.02**
	Tanganyika	30.0	30.0	10.0	-20.0	0.26
Katanga						
	Haut Katanga	55.2	75.0	77.8	22.6	0.07*
	Lualaba	50.0	66.7	33.3	-16.7	0.43
Kasai						
	Sankuru	37.5	43.8	18.8	-18.8	0.24
	Kasai Oriental	22.2	21.1	26.3	4.1	0.77

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Table 3.21b. Hospitals with functional electricity on the day of the survey, by province and survey round

		Matched panel (n=24)			
		2021%	2024%	PP diff (2021 vs 2024)	p-value (2021 vs 2024)
Overall (3 provinces)		54.2	58.3	4.2	0.77
Katanga					
	Haut Lomami	66.7	55.6	-11.1	0.63
Kasai					
	Kasai Central	50.0	75.0	25.0	0.30
	Lomami	42.9	42.9	0.0	1.00

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

The availability of Internet at HCs was low, at 9.8 percent overall in 2024 in the 2019/2024 panel and 3.8 percent in the 2021/2024 panel (Tables 3.22a and 3.22b). In four provinces—Tanganyika, Sankuru, Kasai Oriental, and Lomami—none of the surveyed HCs had Internet. Notably, the prevalence of Internet in Sud Kivu increased from 2.3 percent of HCs in 2019 and 2021 to 27.9 percent in 2024, a statistically significant difference.

Table 3.22a. Health centers with Internet, by province and survey round

		Matched panel (n=296)				
		2019%	2021%	2024%	PP diff (2019 vs 2024)	p-value (2019 vs 2024)
Overall (6 provinces)		3.5	2.0	9.8	6.4	<0.01***
Eastern Congo						
	Sud Kivu	2.3	2.3	27.9	25.6	<0.01***
	Tanganyika	3.9	0.0	0.0	-3.9	0.31
Katanga						
	Haut Katanga	12.3	6.9	3.5	-8.8	0.08*
	Lualaba	0.0	0.0	8.6	8.6	0.09*
Kasai						
	Sankuru	0.0	0.0	0.0	0.0	1.00
	Kasai Oriental	0.0	0.0	0.0	0.0	1.00

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Table 3.22b. Health centers with Internet, by province and survey round

		Matched panel (n=158)			
		2021%	2024%	PP diff (2021 vs 2024)	p-value (2021-2024)
Overall (3 provinces)		5.7	3.8	-1.9	0.43
Katanga					
	Haut Lomami	5.6	2.8	-2.8	0.56
Kasai					
	Kasai Central	8.1	6.8	-1.4	0.75
	Lomami	2.1	0.0	-2.1	0.32

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Internet was more common at hospitals, at 26.7 percent of the hospitals in the 2019/2024 panel and 25 percent in the 2021/2024 panel reporting the availability of the Internet in 2024 (Tables 3.23a and 3.23b). However, there were no significant changes in Internet prevalence, and one province (Sankuru) did not have Internet at any hospital in any of the three survey waves.

Table 3.23a. Hospitals with Internet, by province and survey round

		2019%	2021%	2024%	PP diff (2019 vs 2024)	p-value (2019 vs 2024)
Overall (6 provinces)		19.5	19.0	26.7	7.3	0.19
Eastern Congo						
	Sud Kivu	33.3	26.7	51.6	18.3	0.15
	Tanganyika	10.0	10.0	10.0	0.0	1.00
Katanga						
	Haut Katanga	17.2	25.0	18.5	1.3	0.90
	Lualaba	20.0	16.7	33.3	13.3	0.48
Kasai						
	Sankuru	0.0	0.0	0.0	0.0	1.00
	Kasai Oriental	22.2	21.1	26.3	4.1	0.77

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Table 3.23b. Hospitals with Internet, by province and survey round

		Matched panel (n=24)			
		2021%	2024%	PP diff (2021 vs 2024)	p-value (2021-2024)
Overall (3 provinces)		33.3	25.0	-8.3	0.53
Katanga					
	Haut Lomami	11.1	11.1	0.0	1.00
Kasai					
	Kasai Central	62.5	37.5	-25.0	0.32
	Lomami	28.6	28.6	0.0	1.00

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Overall, the percentage of HCs with improved sanitation was more than 80 percent (Tables 3.24a and 3.24b). Significant improvements were observed in Sud Kivu and Tanganyika between 2019 and 2024, and a significant decrease was noted in Lomami between 2021 and 2024.

Table 3.24a. Health centers with improved sanitation, by province and survey round

		Matched panel (n=296)				
		2019%	2021%	2024%	PP diff (2019 vs 2024)	p-value (2019 vs 2024)
Overall (6 provinces)		84.1	86.1	87.8	3.7	0.20
Eastern Congo						
	Sud Kivu	87.2	95.4	95.4	8.1	0.06*
	Tanganyika	46.2	80.8	80.8	34.6	0.01**
Katanga						
	Haut Katanga	94.7	94.8	89.7	-5.1	0.31
	Lualaba	81.8	82.9	77.1	-4.7	0.63
Kasai						
	Sankuru	79.5	65.0	75.0	-4.5	0.64
	Kasai Oriental	91.8	82.0	94.0	2.2	0.68

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Table 3.24b. Health centers with improved sanitation, by province and survey round

		Matched panel (n=158)			
		2021%	2024%	PP diff (2021 vs 2024)	p-value (2021-2024)
Overall (3 provinces)		87.3	81.0	-6.3	0.12
Katanga					
	Haut Lomami	86.1	77.8	-8.3	0.36
Kasai					
	Kasai Central	89.2	91.9	2.7	0.57
	Lomami	85.4	66.7	-18.8	0.03**

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Hospitals performed better overall, with more than 90 percent having improved sanitation (Tables 3.25a and 3.25b). In 2024, 100 percent of hospitals in Sud Kivu, Kasai Central, and Lomami had improved sanitation.

Table 3.25a. Hospitals with improved sanitation, by province and survey round

		Matched panel (n=116)				
		2019%	2021%	2024%	PP diff (2019 vs 2024)	p-value (2019 vs 2024)
Overall (6 provinces)		95.6	94.8	91.3	-4.3	0.20
Eastern Congo						
	Sud Kivu	100.0	100.0	100.0	0.0	1.00
	Tanganyika	70.0	100.0	90.0	20.0	0.26
Katanga						
	Haut Katanga	96.6	100.0	92.6	-4.0	0.51
	Lualaba	100.0	100.0	91.7	-8.3	0.35
Kasai						
	Sankuru	100.0	81.3	81.3	-18.8	0.07*
	Kasai Oriental	94.4	89.5	89.5	-5.0	0.58

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Table 3.25b. Hospitals with improved sanitation, by province and survey round

	Matched panel (n=24)			
	2021%	2024%	PP diff (2021 vs 2024)	p-value (2021-2024)
Overall (3 provinces)	95.8	95.8	0.0	1.00
Katanga				
Haut Lomami	100.0	88.9	-11.1	0.30
Kasai				
Kasai Central	100.0	100.0	0.0	1.00
Lomami	85.7	100.0	14.3	0.30

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Approximately half of the HCs had a private delivery room. The prevalence of private delivery rooms decreased significantly in Sankuru between 2019 and 2024 (Table 3.26a) and in the 2021/24 panel overall (Table 3.26b).

Table 3.26a. Health centers with a private delivery room, by province and survey round

	Matched panel (n=296)				
	2019%	2021%	2024%	PP diff (2019 vs 2024)	p-value (2019 vs 2024)
Overall (6 provinces)	54.8	40.7	49.2	-5.7	0.17
Eastern Congo					
Sud Kivu	26.7	19.8	38.4	11.6	0.10
Tanganyika	84.6	46.2	73.1	-11.5	0.31
Katanga					
Haut Katanga	47.4	10.3	55.2	7.8	0.40
Lualaba	24.2	37.1	28.6	4.3	0.69
Kasai					
Sankuru	87.2	82.5	20.0	-67.2	<0.01***
Kasai Oriental	91.8	78.0	86.0	-5.8	0.36

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Table 3.26b. Health centers with a private delivery room, by province and survey round

		Matched panel (n=158)			
		2021%	2024%	PP diff (2021 vs 2024)	p-value (2021-2024)
Overall (3 provinces)		70.9	52.5	-18.4	<0.01***
Katanga					
	Haut Lomami	66.7	61.1	-5.6	0.62
Kasai					
	Kasai Central	70.3	47.3	-23.0	<0.01***
	Lomami	75.0	54.2	-20.8	0.03**

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

The percentage of hospitals with a private delivery room also decreased significantly overall in the 2019/24 panel (Table 3.27a). It also decreased, but not significantly, in the 2021/24 panel (Table 3.27b).

Table 3.27a. Hospitals with a private delivery room, by province and survey round

		Matched panel (n=116)				
		2019%	2021%	2024%	PP diff (2019 vs 2024)	p-value (2019 vs 2024)
Overall (6 provinces)		69.9	45.7	50.0	-19.9	<0.01***
Eastern Congo						
	Sud Kivu	66.7	26.7	41.9	-24.7	0.05*
	Tanganyika	100.0	70.0	40.0	-60.0	<0.01***
Katanga						
	Haut Katanga	55.2	28.6	70.4	15.2	0.24
	Lualaba	20.0	33.3	33.3	13.3	0.48
Kasai						
	Sankuru	93.8	68.8	12.5	-81.3	<0.01***
	Kasai Oriental	88.9	73.7	84.2	-4.7	0.68

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Table 3.27b. Hospitals with a private delivery room, by province and survey round

		Matched panel (n=24)			
		2021%	2024%	PP diff (2021 vs 2024)	p-value (2021 vs 2024)
Overall (3 provinces)		79.2	66.7	-12.5	0.33
Katanga					
	Haut Lomami	100.0	100.0	0.0	1.00
Kasai					
	Kasai Central	62.5	62.5	0.0	1.00
	Lomami	71.4	28.6	-42.9	0.11

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Tracer Drugs in Stock

The survey assessed whether nine tracer drugs were in stock on the day of the survey. Although the percentage of HCs with all tracer drugs in stock was very low, there were significant improvements in six of the nine drugs between 2019 and 2024 (Table 3.28a). The drugs least likely to be in stock were iron sulfate, and rifampicin and isoniazid. There were improvements in only five of the nine tracer drugs in the 2021/2024 panel (Tables 3.28a and 3.28b).

Table 3.28a. Health centers with tracer drugs in stock on the day of the survey, by province and survey round

	Matched panel (n=296)				
	2019%	2021%	2024%	PP diff (2019 vs 2024)	p-value (2019 vs 2024)
Oxytocin	78.8	86.8	89.9	11.0	<0.01***
Artesunate-amodiaquine	73.0	75.3	82.4	9.4	<0.01***
Oral rehydration salts	57.0	79.3	84.5	27.5	<0.01***
Depo Provera	59.7	65.4	68.6	8.9	0.03**
Folic acid	55.0	59.3	62.2	7.2	0.08*
Iron sulfate	27.3	35.9	31.8	4.5	0.24
Rifampicin and isoniazid	21.2	25.1	24.3	3.2	0.36
Mebendazole	74.1	69.8	69.9	-4.1	0.27
Amoxycillin	67.9	80.0	76.7	8.8	0.02**
All tracer drugs	3.1	2.4	2.7	-0.4	0.79

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Table 3.28b. Health centers with tracer drugs in stock on the day of the survey, by province and survey round

	Matched panel (n=158)			
	2021%	2024%	PP diff (2021 vs 2024)	p-value (2021 vs 224)
Oxytocin	88.6	88.0	-0.6	0.86
Artesunate-amodiaquine	75.3	86.1	10.8	0.02*
Oral rehydration salts	93.7	86.7	-7.0	0.04*
Depo Provera	62.0	73.4	11.4	0.03*
Folic acid	72.8	58.2	-14.6	<0.01***
Iron sulfate	51.9	39.9	-12.0	0.03*
Rifampicin and isoniazid	28.5	22.8	-5.7	0.25
Mebendazole	81.7	75.3	-6.3	0.17
Amoxycillin	84.2	87.3	3.2	0.42
All tracer drugs	5.7	5.7	0.0	1.00

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

The percentage of hospitals with all nine tracer drugs in stock likewise did not change significantly, but it was higher overall in hospitals compared with HCs (Tables 3.29a and 3.29b).

Table 3.29a. Hospitals with tracer drugs in stock on the day of the survey, by survey round

	2019%	2021%	2024%	PP diff (2019 vs 2024)	p-value (2019 vs 2024)
Oxytocin	94.8	94.0	96.6	1.7	0.52
Artesunate-amodiaquine	74.1	80.3	87.9	13.8	<0.01***
Oral rehydration salts	73.3	86.3	95.7	22.4	<0.01***
Depo Provera	62.1	68.4	76.7	14.7	0.02**
Folic acid	62.1	79.5	69.8	7.8	0.21
Iron sulfate	50.0	54.7	46.6	-3.5	0.60
Rifampicin and isoniazid	74.1	59.0	59.5	-14.7	0.02**
Mebendazole	81.0	82.9	76.7	-4.3	0.42
Amoxycillin	92.2	91.5	98.3	6.0	0.03**
All tracer drugs	12.1	19.7	18.1	6.0	0.20

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Table 3.29b. Hospitals with tracer drugs in stock on the day of the survey, by survey round

	Matched panel (n=24)			
	2021%	2024%	PP diff (2021 vs 2024)	p-value (2021 vs 224)
Oxytocin	100.0	79.2	-20.8	0.02**
Artesunate-amodiaquine	100.0	70.8	-29.2	<0.01***
Oral rehydration salts	100.0	91.7	-8.3	0.15
Depo Provera	75.0	66.7	-8.3	0.53
Folic acid	79.2	79.2	0.0	1.00
Iron sulfate	62.5	45.8	-16.7	0.25
Rifampicin and isoniazid	75.0	70.8	-4.2	0.75
Mebendazole	70.8	91.7	20.8	0.06*
Amoxycillin	87.5	100.0	12.5	0.07*
All tracer drugs	20.8	20.8	0.0	1.00

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

The percentage of HCs with male condoms, Depo Provera, and implants in stock increased significantly between 2019 and 2024 (Table 3.30a). This was driven mainly by increases in the availability of implants, which was seen in both the 2019/24 and 2021/24 panels (Tables 3.30a and 3.30b).

Table 3.30a. Health centers that had at least three contraceptives available in stock on the day of the survey: Depo Provera, male condom, and implants (one or two rod implants)

	Matched panel (n=296)				
	2019%	2021%	2024%	PP diff (2019 vs 2024)	p-value (2019 vs 2024)
Male condom	66.9	70.9	65.9	-1.0	0.79
Depo Provera	59.7	65.4	68.6	8.9	0.03**
Implants	53.2	70.9	74.7	21.4	<0.01***
All three methods	34.5	46.4	43.9	9.5	0.02**

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Table 3.30b. Health centers that had at least three contraceptives available in stock on the day of the survey: Depo Provera, male condom, and implants (one or two rod implants)

	Matched panel (n=158)			
	2021%	2024%	PP diff (2021 vs 2024)	p-value (2021 vs 224)
Male condom	55.1	58.2	3.2	0.57
Depo Provera	62.0	73.4	11.4	0.03**
Implants	63.3	76.6	13.3	0.01**
All three methods	35.4	42.4	7.0	0.20

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Similar trends were observed for hospitals, with overall improvements driven mainly by increases in the availability of implants (Tables 3.31a and 3.31b).

Table 3.31a. Hospitals that had at least three contraceptives available in stock on the day of the survey: Depo Provera, male condom, and implants (one or two rod implants)

	Matched panel (n=116)				
	2019%	2021%	2024%	PP diff (2019 vs 2024)	p-value (2019 vs 2024)
Male condom	81.9	69.2	76.7	-5.2	0.33
Depo Provera	62.1	68.4	76.7	14.7	0.02**
Implant	69.8	78.6	91.4	21.6	<0.01***
All three methods	53.5	49.6	64.7	11.2	0.08*

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Table 3.31b. Hospitals that had at least three contraceptives available in stock on the day of the survey: Depo Provera, male condom, and implants (one or two rod implants)

	Matched panel (n=24)			
	2021%	2024%	PP diff (2021 vs 2024)	p-value (2021 vs 224)
Male condom	79.2	70.8	-8.3	0.51
Depo Provera	75.0	66.7	-8.3	0.53
Implant	83.3	87.5	4.2	0.68
All three methods	58.3	45.8	-12.5	0.39

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Equipment

The percentage of HCs with all six pieces of basic equipment on the day of the survey increased significantly from 35.8 percent in 2019 to 53 percent in 2024 (Table 3.32a). Significant increases were noted in the availability of infant scales and light sources. The 2021/24 panel saw a significant increase in the availability of both adult and infant scales (Table 3.32b).

Table 3.32a. Health centers with pieces of basic equipment on the day of the survey, by survey round

	Matched panel (n=296)				
	2019%	2021%	2024%	PP diff (2019 vs 2024)	p-value (2019 vs 2024)
Stethoscope	90.1	91.6	91.6	1.5	0.54
Thermometer	87.4	87.8	89.9	2.5	0.34
Blood pressure monitor	81.9	81.1	82.8	0.9	0.79
Adult scale	80.6	84.5	83.5	2.9	0.36
Infant scale	67.6	76.0	82.4	14.9	<0.01***
Light source (spotlight)	62.8	67.2	73.7	10.9	<0.01***
All basic equipment	35.8	44.9	53.0	17.2	<0.01***

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Table 3.32b. Health centers with pieces of basic equipment on the day of the survey, by survey round

	Matched panel (n=158)			
	2021%	2024%	PP diff (2021 vs 2024)	p-value (2021 vs 224)
Stethoscope	96.2	94.9	-1.3	0.59
Thermometer	93.7	93.7	0.0	1.00
Blood pressure monitor	91.1	89.2	-1.9	0.57
Adult scale	70.3	81.7	11.4	0.02**
Infant scale	76.6	86.1	9.5	0.03**
Light source (spotlight)	68.4	61.4	-7.0	0.20
All basic equipment	39.9	47.5	7.6	0.17

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

At hospitals, the availability of all six pieces of equipment did not change significantly between 2019 and 2024, although it was relatively high, at 81.9 percent, in 2024 (Table 3.33a). No significant differences were noted in the 2021/24 panel (Table 3.33b).

Table 3.33a. Hospitals with pieces of basic equipment on the day of the survey, by survey round

	Matched panel (n=116)				
	2019%	2021%	2024%	PP diff (2019 vs 2024)	p-value (2019 vs 2024)
Stethoscope	95.7	94.9	98.3	2.6	0.25
Thermometer	95.7	94.0	96.6	0.9	0.73
Blood pressure monitor	96.6	95.7	94.0	-2.6	0.35
Adult scale	93.1	91.5	97.4	4.3	0.12
Infant scale	97.4	92.3	94.0	-3.4	0.20
Light source (spotlight)	81.0	85.5	88.8	7.8	0.10*
All basic equipment	74.1	73.5	81.9	7.8	0.15

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Table 3.33b. Hospitals with pieces of basic equipment on the day of the survey, by survey round

	Matched panel (n=24)			
	2021%	2024%	PP diff (2021 vs 2024)	p-value (2021 vs 224)
Stethoscope	100.0	100.0	0.0	1.00
Thermometer	100.0	100.0	0.0	1.00
Blood pressure monitor	100.0	100.0	0.0	1.00
Adult scale	100.0	100.0	0.0	1.00
Infant scale	91.7	95.8	4.2	0.55
Light source (spotlight)	75.0	87.5	12.5	0.27
All basic equipment	70.8	83.3	12.5	0.30

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

When examining the presence of delivery equipment, significant increases in newborn tables and delivery tables were noted at HCs between 2019 and 2024 (Table 3.34a). No significant differences were noted in the 2021/24 panel (Table 3.34b).

Table 3.34a. Health centers with select pieces of delivery equipment on the day of the survey, by survey round

	Matched panel (n=296)				
	2019%	2021%	2024%	PP diff (2019 vs 2024)	p-value (2019 vs 2024)
Table to care for newborns	39.6	41.6	48.7	9.1	0.03**
Delivery kit	72.7	69.6	70.6	-2.1	0.57
Episiotomy kit	41.6	41.6	46.3	4.6	0.26
Delivery table with stirrups	53.2	55.1	63.5	10.3	0.01**

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Table 3.34b. Health centers with select pieces of delivery equipment on the day of the survey, by survey round

	Matched panel (n=158)			
	2021%	2024%	PP diff (2021 vs 2024)	p-value (2021 vs 224)
Table to care for newborns	59.5	62.0	2.5	0.65
Delivery kit	68.4	74.7	6.3	0.21
Episiotomy kit	35.4	44.3	8.9	0.11
Delivery table with stirrups	65.8	69.0	3.2	0.55

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

The survey also collected data on the presence of 11 pieces of infection control equipment. A large and significant increase in the presence of masks was observed between 2019 and 2024 (Table 3.35a). The presence of eye protection also increased significantly in that timeframe. Interestingly, in the 2021/24 panel, the availability of masks increased, but the availability of eye protection decreased significantly (Table 3.35b). Sharps boxes also became more prevalent during that time.

Table 3.35a. Health centers with all 11 pieces of infection control equipment, by survey round

	Matched panel (n=296)				
	2019%	2021%	2024%	PP diff (2019 vs 2024)	p-value (2019 vs 2024)
Safe final disposal of biohazards	27.3	30.1	31.8	4.5	0.24
Gowns	73.0	62.8	69.3	-3.8	0.31
Sharps box	70.7	67.6	76.4	5.7	0.12
Gloves	64.9	54.4	60.1	-4.7	0.24
Sink or basin	62.8	75.3	68.2	5.4	0.16
Clean water	50.5	50.7	54.4	3.9	0.35
Autoclave (steam sterilizer)	16.0	15.2	19.6	3.6	0.26
Disinfectant (chlorine powder)	23.9	29.4	23.7	-0.2	0.95
Masks	22.9	42.2	79.1	56.2	<0.01***
Eye protection	7.9	16.2	17.2	9.4	<0.01***
Test strips	3.1	2.7	2.7	-0.4	0.79
All infection control materials	0.3	0.3	0.0	-0.3	0.31

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Table 3.35b. Health centers with all 11 pieces of infection control equipment, by survey round

	Matched panel (n=158)			
	2021%	2024%	PP diff (2021 vs 2024)	p-value (2021 vs 224)
Safe final disposal of biohazards	36.7	26.6	-10.1	0.05*
Gowns	77.2	77.9	0.6	0.89
Sharps box	51.9	66.5	14.6	<0.01***
Gloves	78.5	75.3	-3.2	0.51
Sink or basin	76.6	74.1	-2.5	0.60
Clean water	39.2	32.9	-6.3	0.24
Autoclave (steam sterilizer)	15.2	19.0	19.6	0.37
Disinfectant (chlorine powder)	13.3	13.3	0.0	1.00
Masks	51.9	65.2	13.3	0.02**
Eye protection	24.1	15.2	-8.9	0.05**
Test strips	3.2	3.2	0.0	1.00
All infection control materials	0.0	0.6	0.6	0.32

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Hospitals also saw significant increases in the presence of masks and eye protection between 2019 and 2024 (Table 3.36a). No significant changes were seen in hospitals in the 2021/24 panel (Table 3.36b).

Table 3.36a. Hospitals with all 11 pieces of infection control equipment, by survey round

	Matched panel (n=116)				
	2019%	2021%	2024%	PP diff (2019 vs 2024)	p-value (2019 vs 2024)
Safe final disposal of biohazards	44.0	43.6	42.2	-1.7	0.79
Gowns	77.6	70.9	79.3	1.7	0.75
Sharps box	78.5	79.5	74.1	-4.3	0.44
Gloves	84.5	82.1	85.3	0.9	0.85
Sink or basin	85.3	83.8	83.6	-1.7	0.72
Clean water	72.4	69.2	71.6	-0.9	0.88
Autoclave (steam sterilizer)	69.8	73.5	67.2	-2.6	0.67
Disinfectant (chlorine powder)	40.5	50.4	44.8	4.3	0.51
Masks	81.9	74.4	90.5	8.6	0.06*
Eye protection	44.0	55.6	56.0	12.1	0.07*
Test strips	15.5	23.1	15.5	0.0	1.00
All infection control materials	2.6	2.6	1.7	-0.9	0.65

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Table 3.36b. Hospitals with all 11 pieces of infection control equipment, by survey round

	Matched panel (n=24)			
	2021%	2024%	PP diff (2021 vs 2024)	p-value (2021 vs 224)
Safe final disposal of biohazards	45.8	29.2	-16.7	0.23
Gowns	87.5	87.5	0.0	1.00
Sharps box	87.5	79.2	-8.3	0.44
Gloves	83.3	95.8	12.5	0.16
Sink or basin	95.8	91.7	-4.2	0.55
Clean water	50.0	50.0	0.0	1.00
Autoclave (steam sterilizer)	58.3	75.0	19.6	0.22
Disinfectant (chlorine powder)	37.5	29.2	-8.3	0.54
Masks	75.0	91.7	16.7	0.12
Eye protection	58.3	41.7	-16.7	0.25
Test strips	12.5	8.3	-4.2	0.64
All infection control materials	0.0	0.0	0.0	1.00

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Overall, approximately 60 percent of hospitals had autoclave equipment in 2024 (Tables 3.37a and 3.37b). The only significant difference observed was in Lomami, where the prevalence of autoclaves increased from 14.3 percent in 2021 to 85.7 percent in 2024 (Table 3.37b). This result comes with the caveat that the sample size in Lomami was quite small.

Table 3.37a. Hospitals with autoclave equipment, by province and survey round

		Matched panel (n=116)				
		2019%	2021%	2024%	PP diff (2019 vs 2024)	p-value (2019 vs 2024)
Overall (6 provinces)		57.0	62.8	59.5	2.5	0.71
Eastern Congo						
	Sud Kivu	54.8	71.4	64.5	9.7	0.44
	Tanganyika	40.0	40.0	30.0	-10.0	0.64
Katanga						
	Haut Katanga	63.0	63.0	66.7	3.7	0.78
	Lualaba	63.6	83.3	66.7	3.0	0.88
Kasai						
	Sankuru	37.5	56.3	62.5	25.0	0.16
	Kasai Oriental	73.7	52.6	52.6	-21.1	0.18

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Table 3.37b. Hospitals with autoclave equipment, by province and survey round

		Matched panel (n=24)			
		2021%	2024%	PP diff (2021 vs 2024)	p-value (2021-2024)
Overall (3 provinces)		45.8	58.3	12.5	0.39
Katanga					
	Haut Lomami	44.4	44.4	0.0	1.00
Kasai					
	Kasai Central	75.0	50.0	-25.0	0.30
	Lomami	14.3	85.7	71.4	<0.01***

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

There were no significant changes in the prevalence of X-ray machines at hospitals, either overall or by province (Tables 3.38a and 3.38b). The highest prevalence in 2024 was in Lualaba (75% of hospitals) and the lowest was in Kasai Central (12.5%).

Table 3.38a. Hospitals with X-ray machines, by province and survey round

		Matched panel (n=116)				
		2019%	2021%	2024%	PP diff (2019 vs 2024)	p-value (2019 vs 2024)
Overall (6 provinces)		57.0	62.0	58.6	1.6	0.81
Eastern Congo						
	Sud Kivu	61.3	64.3	67.7	0.60	0.60
	Tanganyika	60.0	60.0	40.0	0.37	0.37
Katanga						
	Haut Katanga	55.6	59.3	55.6	1.00	1.00
	Lualaba	72.7	83.3	75.0	0.90	0.90
Kasai						
	Sankuru	18.8	25.0	37.5	0.24	0.24
	Kasai Oriental	73.7	84.2	68.4	0.72	0.72

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Table 3.38b. Hospitals with X-ray machines, by province and survey round

		Matched panel (n=24)			
		2021%	2024%	PP diff (2021 vs 2024)	p-value (2021-2024)
Overall (3 provinces)		37.5	25.0	-12.5	0.35
Katanga					
	Haut Lomami	44.4	33.3	-11.1	0.63
Kasai					
	Kasai Central	37.5	12.5	-25.0	0.25
	Lomami	28.6	28.6	0.0	1.00

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Ultrasound machines were very common in 2024 (87.9% of hospitals), with significant increases being observed overall, and in Haut Katanga and Sankuru between 2019 and 2024 (Table 3.39a). Two provinces—Kasai Central and Lomami—reported ultrasound equipment at 100 percent of surveyed hospitals in 2024 (Table 3.39b).

Table 3.39a. Hospitals with ultrasound machines, by province and survey round

	Matched panel (n=116)				
	2019%	2021%	2024%	PP diff (2019 vs 2024)	p-value (2019 vs 2024)
Overall (6 provinces)	79.8	82.3	87.9	8.1	0.09*
Eastern Congo					
Sud Kivu	100.0	100.0	93.6	-6.5	0.15
Tanganyika	100.0	100.0	80.0	-20.0	0.14
Katanga					
Haut Katanga	66.7	70.4	92.6	25.9	0.02**
Lualaba	81.8	83.3	91.7	9.9	0.48
Kasai					
Sankuru	50.0	62.5	81.3	31.3	0.06*
Kasai Oriental	79.0	84.2	84.2	5.3	0.68

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Table 3.39b. Hospitals with ultrasound machines, by province and survey round

	Matched panel (n=24)			
	2021%	2024%	PP diff (2021 vs 2024)	p-value (2021-2024)
Overall (3 provinces)	83.3	95.8	12.5	0.16
Katanga				
Haut Lomami	77.8	88.9	11.1	0.53
Kasai				
Kasai Central	75.0	100.0	25.0	0.13
Lomami	100.0	100.0	0.0	1.00

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

At HCs, there were significant increases in the self-reported capacity to insert and remove intrauterine devices (IUDs) and implants between 2019 and 2024 (Table 3.40a). The 2021/24 panel also saw significant increases in the percentage of HCs capable of inserting and removing implants (Table 3.40b).

Table 3.40a. Percentage of health centers capable of inserting and removing IUDs and implants

	Matched panel (n=296)				
	2019%	2021%	2024%	PP diff (2019 vs 2024)	p-value (2019 vs 2024)
Insert IUD	16.7	31.2	37.8	21.1	<0.01***
Remove IUD	17.4	32.9	37.4	20.1	<0.01***
Insert implant	55.9	76.7	86.1	30.2	<0.01***
Remove implant	58.0	77.1	86.7	28.7	<0.01***

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Table 3.40b. Percentage of health centers capable of inserting and removing IUDs and implants

	Matched panel (n=158)			
	2021%	2024%	PP diff (2021 vs 2024)	p-value (2021 vs 224)
Insert IUD	30.6	36.1	5.5	0.30
Remove IUD	32.5	38.0	5.5	0.31
Insert implant	76.4	86.1	9.6	0.03**
Remove implant	76.4	86.1	9.6	0.03**

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Hospitals saw significant increases in the capacity to insert and remove implants between 2019 and 2024 (Table 3.41a). No significant differences were observed in the 2021/24 panel (Table 3.41b).

Table 3.41a. Percentage of hospitals capable of inserting and removing IUDs and implants

	Matched panel (n=116)				
	2019%	2021%	2024%	PP diff (2019 vs 2024)	p-value (2019 vs 2024)
Insert IUD	64.9	57.8	69.8	4.9	0.43
Remove IUD	65.8	60.3	69.8	4.0	0.51
Insert implant	82.5	87.1	93.1	10.6	0.01**
Remove implant	81.6	87.9	93.1	11.5	<0.01***

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Table 3.41b. Percentage of hospitals capable of inserting and removing IUDs and implants

	Matched panel (n=24)			
	2021%	2024%	PP diff (2021 vs 2024)	p-value (2021 vs 224)
Insert IUD	62.5	56.5	-6.0	0.68
Remove IUD	66.7	56.5	-10.2	0.47
Insert implant	83.3	95.7	12.3	0.17
Remove implant	83.3	95.7	12.3	0.17

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

A summary of key service readiness indicators is shown in Table 3.42. The table characterizes performance as of the 2024 survey, the direction of change between survey waves, and indicates whether the difference is statistically significant.

Table 3.42. Summary of service readiness indicators

Indicator	Performance (2024)	Direction (2019 vs 2024 unless indicated)
Preventive services		
Health centers offering the MOH minimum package of preventive services	Mid-poor	↑ *
Health centers with all six tracer vaccines in stock	Mid-poor	↑ *
Health centers that distributed insecticide-treated nets to patients	Strong	↑ *
Health centers that offered all seven services for pregnant women	Poor	↑ *
Health centers that offered all nine postpartum services	Poor	↑
Curative services		
Health centers offering the MOH's minimum package of curative services	Poor	↑*
Complementary services		
Health centers that offered any malaria screening	Strong	↑
Health centers that offered any TB screening	Poor	↑
Health centers that offered any TB treatment	Mid-poor	↑
Health centers that offered a long-acting or permanent method of FP	Strong	↑ *
Hospitals that offered a long-acting or permanent method of FP	Strong	↑ *
Health centers with FP information and resources specific to youth	Mid-poor	↑ *
Hospitals with FP information and resources specific to youth	Mid-poor	↑
Health centers with comprehensive SGBV services	Mid-poor	↑ *
Hospitals with comprehensive SGBV services	Strong	↑
Infrastructure		
Health centers with a source of electricity	Poor	↑
Hospitals with a source of electricity	Mid-poor	↑
Health centers with Internet	Poor	↑ *
Hospitals with Internet	Mid-poor	↑
Health centers with improved sanitation	Strong	↑
Hospitals with improved sanitation	Strong	↓

Indicator	Performance (2024)	Direction (2019 vs 2024 unless indicated)
Health centers with a private delivery room	Mid-poor	↓
Hospitals with a private delivery room	Mid-strong	↓*
Tracer drugs		
Health centers with all nine tracer drugs in stock on the day of the survey	Poor	↓
Hospitals with all nine tracer drugs in stock on the day of the survey	Poor	↑
Health centers that had at least three contraceptives available in stock on the day of the survey: Depo Provera, male condom, and implants	Mid-poor	↑ *
Hospitals that had at least three contraceptives available in stock on the day of the survey: Depo Provera, male condom, and implants	Mid-strong	↑ *
Equipment		
Health centers with all basic equipment on the day of the survey	Mid-strong	↑ *
Hospitals with all basic equipment on the day of the survey	Strong	↑
Health centers with all 11 pieces of infection control equipment	Poor	↓
Hospitals with all 11 pieces of infection control equipment	Poor	↓
Hospitals with autoclave equipment	Mid-strong	↑
Hospitals with X-ray machines	Mid-strong	↑
Hospitals with ultrasound machines	Strong	↑ *

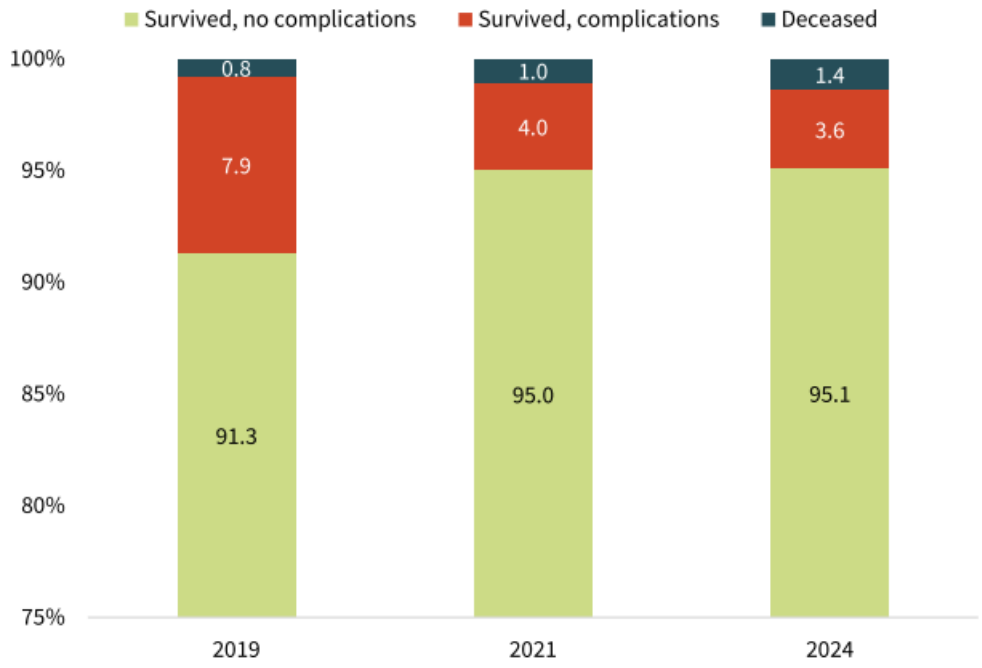
Notes: Strong= 75%–100% of respondents; Mid-Strong= 50%–74% of respondents; Mid-Poor=25%–49% of respondents; Poor=0%–24% of respondents overall in 2024. Arrows indicate the direction of change between 2019 and 2024 in the matched panel. * indicates that the change was statistically significant at p<0.1.

Service Delivery

Medical Record Review

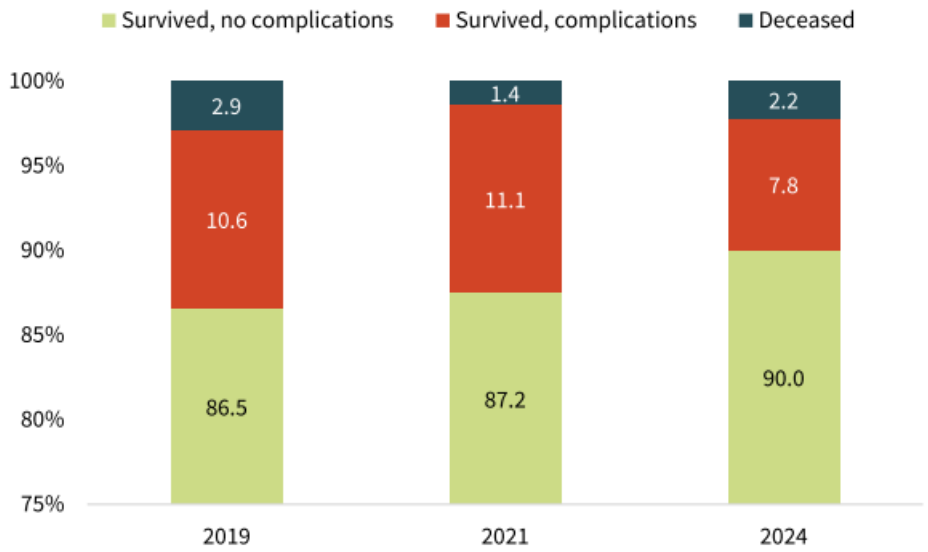
The results of the medical record review shown here are from the 2019/2024 panel facilities in the six provinces surveyed in all three waves. The percentage of HC deliveries in which no complications were recorded increased from 91.3 percent in 2019 to 95.1 percent in 2024 (Figure 4.1). The overall rate of complications decreased after 2019 but was relatively unchanged between 2021 and 2024. In 2024, the maternal mortality rate was 1.4 percent at HCs, up from 0.8 percent in 2019.

Figure 4.1 Health center maternal delivery outcomes, among those for whom an outcome was recorded, by survey round (2019/2024 panel facilities)



The percentage of hospital-based deliveries in which no complications were recorded increased from 86.5 percent in 2019 to 90.0 percent in 2024 (Figure 4.2). Moreover, the overall rate of complications decreased in each subsequent round of data collection. In 2024, the maternal mortality rate was 2.2 percent at hospitals, down from 2.9 percent in 2019.

Figure 4.2. Hospital maternal delivery outcomes, among those for whom an outcome was reported, by survey round (2019/2024 panel facilities)



The most frequently recorded complication at HCs was postpartum hemorrhage, which decreased from 2.9 percent of deliveries in 2019 to 2.2 percent in 2024 (Table 4.1). The percentage of deliveries in which the outcome was maternal death with no complication recorded was 4.1 percent in 2019 but decreased to 1.2 percent in 2024.

Table 4.1. Health center delivery complications and maternal survival status among those for whom an outcome was recorded, by survey round

	2019	2021	2024
Antepartum hemorrhage	2.0	1.3	1.2
Survived	2.0	1.2	1.1
Deceased	0.0	0.0	0.1
Postpartum hemorrhage	2.9	2.4	2.2
Survived	2.4	2.4	2.1
Deceased	0.4	0.0	0.0
Postpartum infection	0.8	1.2	0.8
Survived	0.8	1.2	0.7
Deceased	0.0	0.0	0.1
Deceased but no complication recorded	4.1	1.0	1.2

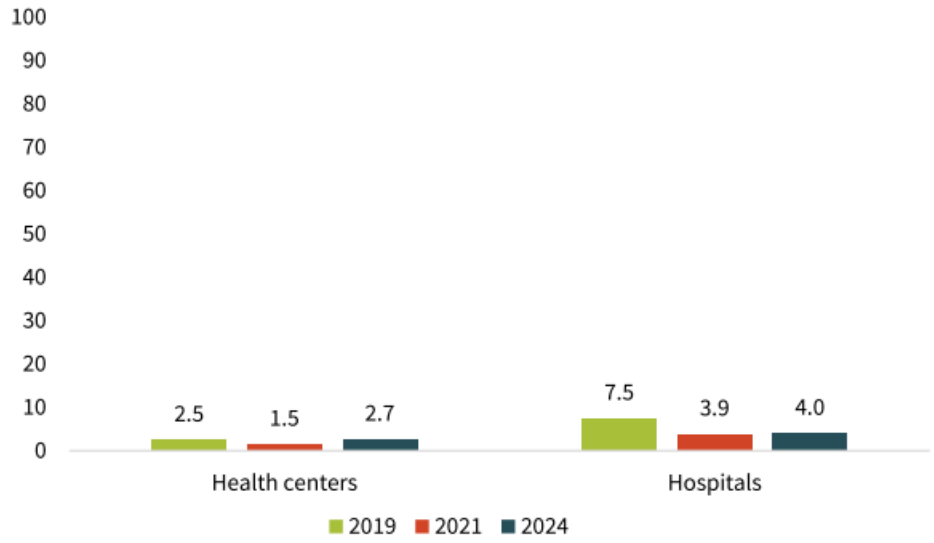
The most frequently recorded complication in hospitals was also postpartum hemorrhage, which decreased from 7.7 percent of deliveries in 2019 to 4.5 percent in 2024 (Table 4.2). Rates of antepartum hemorrhage also decreased over time. The percentage of deliveries with an outcome of maternal death for which there was no complication recorded was 1.9 percent in 2019 but decreased to 1.2 percent in 2024.

Table 4.2. Hospital delivery complications and maternal survival status among those for whom an outcome was recorded, by survey round (2019/2024 panel)

	2019	2021	2024
Antepartum hemorrhage	5.8	5.4	4.0
Survived	4.8	5.4	4.0
Deceased	1.0	0.0	0.0
Postpartum hemorrhage	7.7	7.6	4.5
Survived	6.7	7.5	4.3
Deceased	1.0	0.1	0.3
Postpartum infection	1.0	2.2	0.9
Survived	1.0	2.1	0.7
Deceased	0.0	0.1	0.2
Deceased but no complication recorded	1.9	1.1	1.2

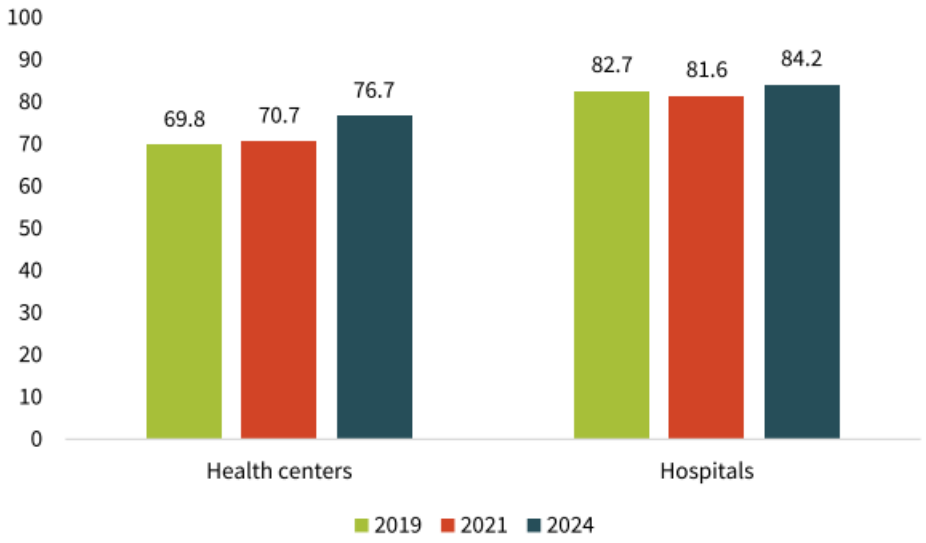
At HCs, the neonatal death rate was higher in 2024 compared with 2019, after experiencing a one PP decrease in 2021 (Figure 4.3). The neonatal death rate at hospitals, while generally higher than at HCs, was much lower in 2021 and 2024 compared with 2019.

Figure 4.3. Percentage of deliveries in which the child died within 7 days of birth (includes stillbirth) among those for whom an outcome was recorded, by facility type and survey round (2019/2024 panel)



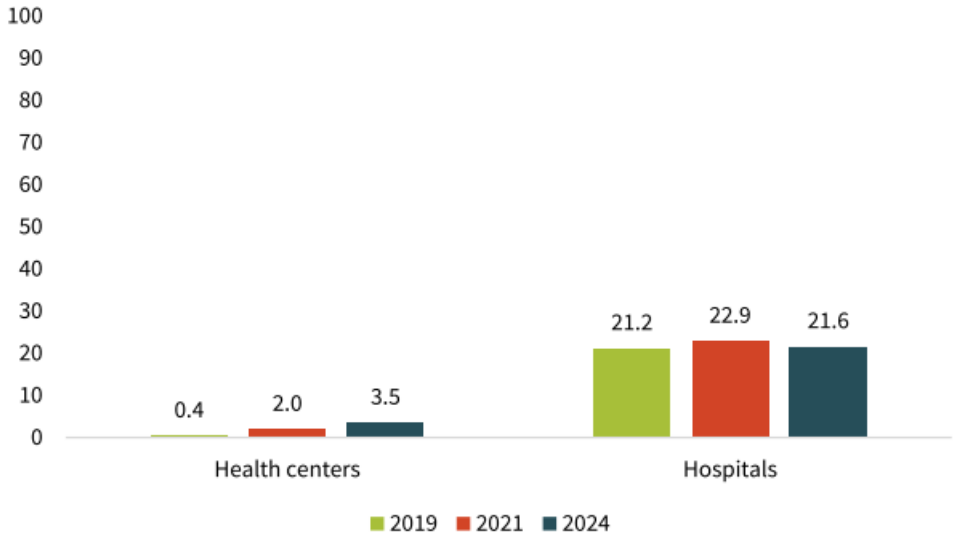
The percentage of births with active management of the third stage of labor increased between 2019 and 2024 at both HCs and hospitals, with hospitals performing better overall (Figure 4.4).

Figure 4.4. Percentage of deliveries with active management of the third stage of labor among those for whom an outcome was recorded, by facility type and survey round (2019/2024 panel)



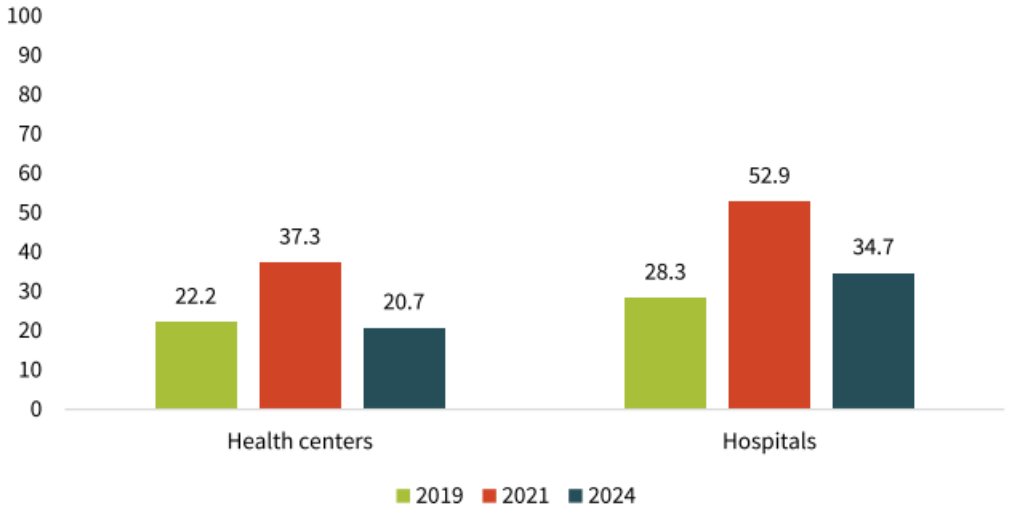
Rates of delivery by caesarean (C)-section increased at HCs, from less than one percent in 2019 to 3.5 percent in 2024 (Figure 4.5). This trend was not reflected at hospitals, where C-section rates were relatively steady across the three rounds of data collection, increasing from 21.2 percent in 2019 to 21.6 percent in 2024.

Figure 4.5. Percentage of deliveries that were C-sections among those for whom an outcome was recorded, by facility type and survey round (2019/2024 panel)



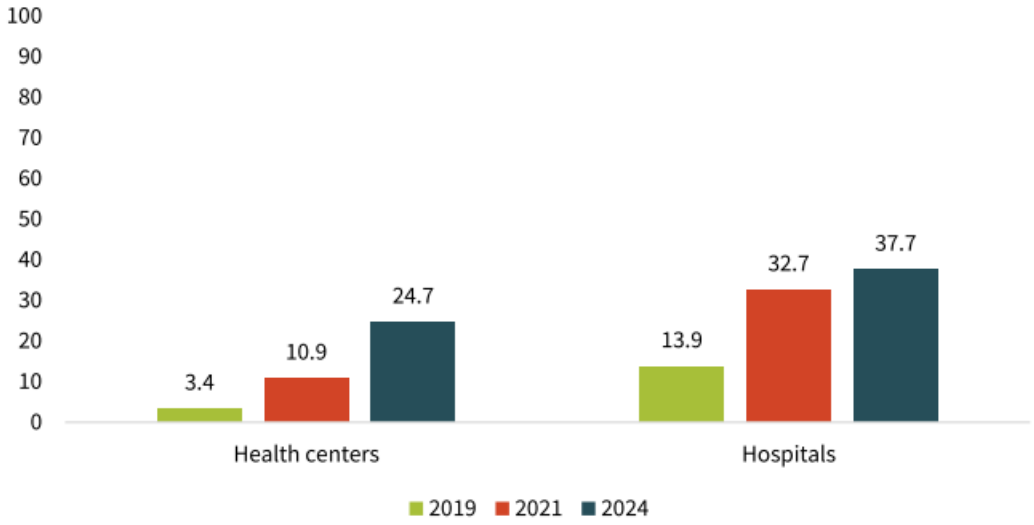
At both HCs and hospitals, the percentage of ANC1 patients whose blood pressure was measured was highest in 2021 (Figure 4.6). HCs saw a decrease between 2019 and 2024, whereas hospitals saw an increase (28.3% to 34.7% of patients).

Figure 4.6. Percentage of ANC1 patients whose blood pressure was measured, by facility type and survey round (2019/2024 panel)



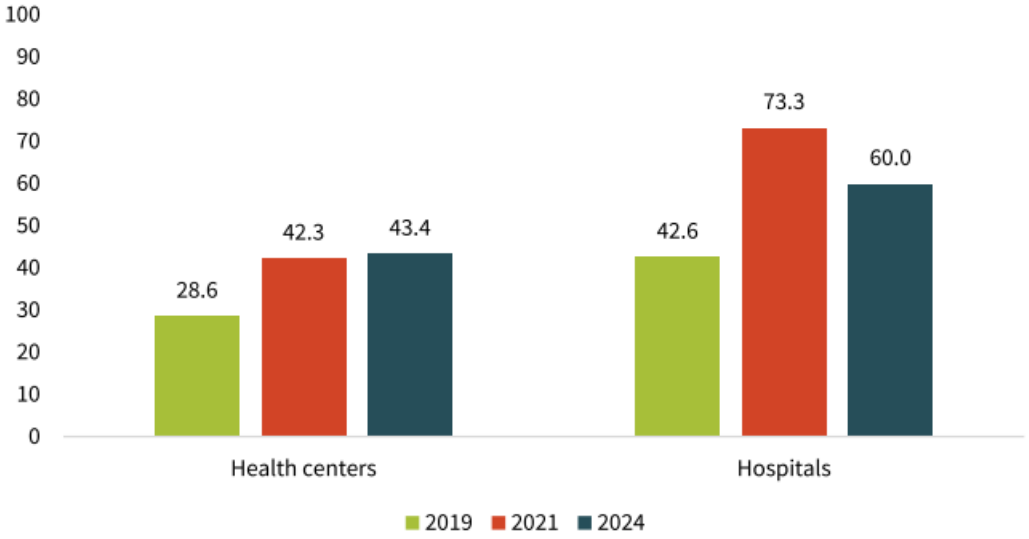
At both HCs and hospitals, the percentage of ANC1 patients who were tested for syphilis increased in each survey round, with large increases occurring overall (Figure 4.7). HCs increased from less than 4 percent in 2019 to approximately 25 percent in 2024, and hospitals increased from 13.9 percent to 37.7 percent.

Figure 4.7. Percentage of ANC1 patients who were tested for syphilis, by facility type and survey round (2019/2024 panel)



At HCs, the percentage of ANC1 patients who were tested for HIV increased between 2019 and 2021, then leveled off (Figure 4.8). At hospitals, HIV testing increased from 42.6 percent to 73.3 percent from 2019 to 2021, then decreased to 60 percent in 2024.

Figure 4.8. Percentage of ANC1 patients who were tested for HIV, by facility type and survey round (2019/2024 panel)



Clinical Vignettes

The number of health workers who responded to each clinical vignette is shown in Tables 4.3 and 4.4.

Table 4.3. Total number of health center-based workers who responded to each clinical vignette, by survey round

	2019	2021	2024
Child health	694	N/A	407
FP	342	393	307

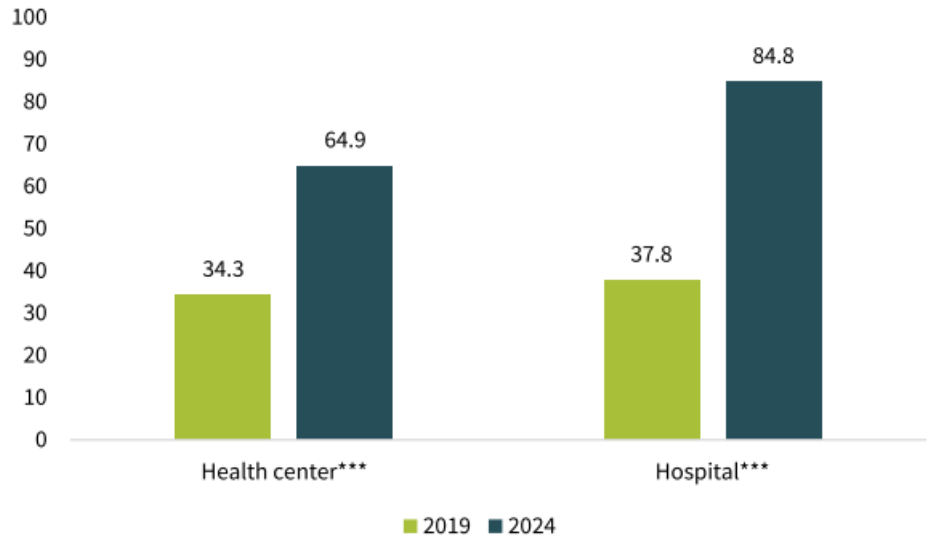
Table 4.4. Total number of hospital-based workers who responded to each clinical vignette, by survey round

	2019	2021	2024
Child health	328	N/A	164
FP	172	184	133

Child Health Differential Diagnosis

The percentage of health workers who correctly included shigella/dysentery in their differential diagnosis for the child health vignette increased significantly at both HCs and hospitals (Figure 4.9). Notably, the rate more than doubled at hospitals between 2019 and 2024.

Figure 4.9. Percentage of health workers who correctly included shigella/dysentery in their differential diagnosis in the child health vignette, by facility type and year (2019/2024 panel)

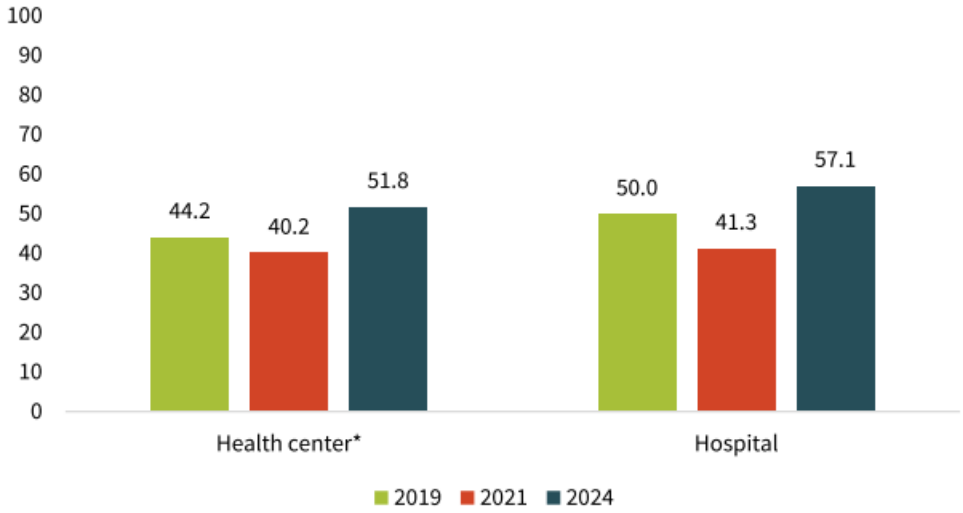


Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01.

Family Planning Visit Outcome

Health workers were presented with a case of a 22-year-old married woman with no children. She presented to the health facility without her husband, asking for contraception. The only method she was currently using was condoms. The standard of care is to offer her a method. The percentage of HC-based workers who would do so increased significantly from 44.2 percent in 2019 to 51.8 percent in 2024, after dipping slightly in 2021 (Figure 4.10). Hospitals followed a similar pattern with the percentage increasing from 50 percent to 57.1 percent.

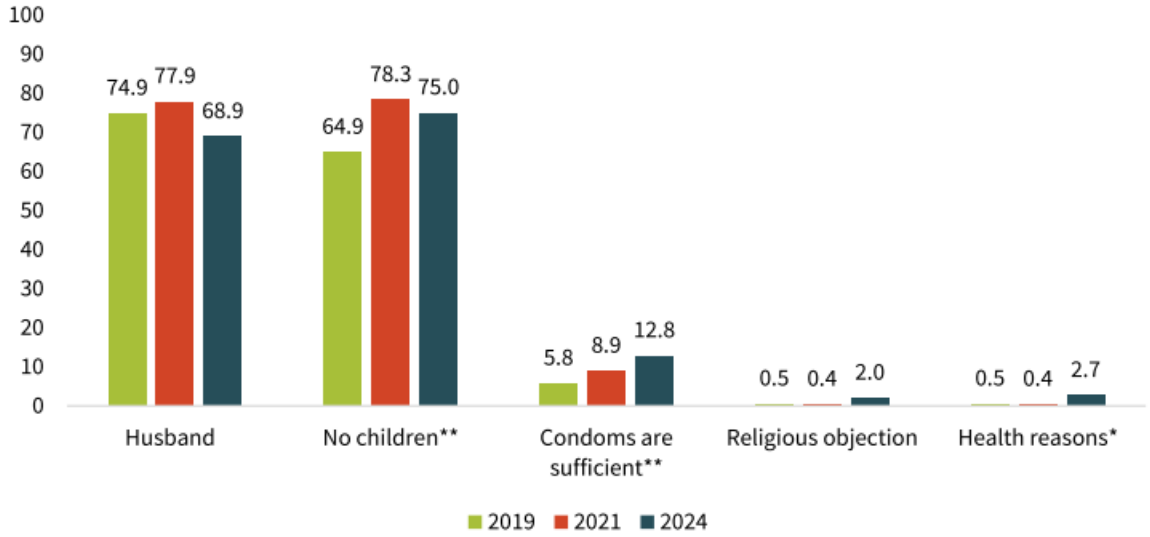
Figure 4.10. Percentage of health workers who would prescribe a contraceptive method to a 22-year-old married woman with no children who was not accompanied by her husband, by facility type and year (2019/2024 panel)



Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01.

The health workers who indicated that they would not offer the patient a contraceptive method were asked their reasons. At HCs, the most commonly cited reasons had to do with her husband (that she was married and/or that he was not present), and the fact that she did not yet have any children (Figure 4.11). A much smaller but growing percentage thought that condoms were sufficient. Fewer than 3 percent had religious objections or mentioned health-related reasons for not offering her a method.

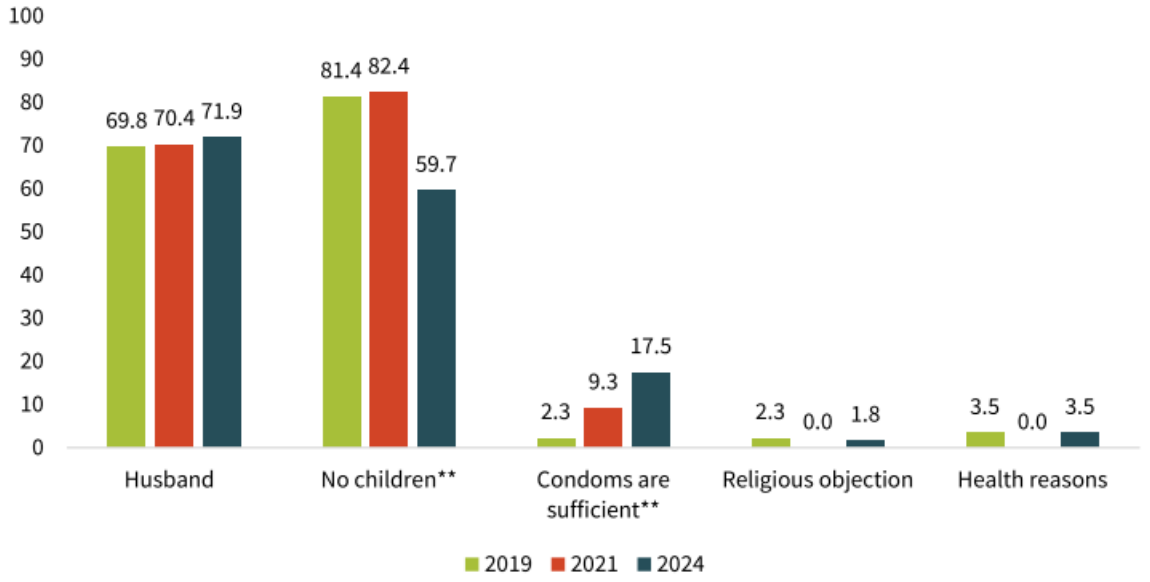
Figure 4.11. Among health center-based workers who would not prescribe a contraceptive method to a 22-year-old married woman with no children who was not accompanied by her husband, reasons cited, by facility type and year (2019/2024 panel)



Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01.

Hospital-based workers were also concerned about the woman's marital status and the fact that she had no children, although the percentage citing "no children" declined substantially in 2024 compared with previous years (Figure 4.12). There was also growing support for the continued use of condoms, with 17.5 percent of health workers citing this as a reason in 2024.

Figure 4.12. Among hospital-based workers who would not prescribe a contraceptive method to a 22-year-old married woman with no children who was not accompanied by her husband, reasons cited, by facility type and year (2019/2024 panel)



Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01.

User Fees and Payment Policies

Fee schedules were present at more than 80 percent of HCs and more than 90 percent of hospitals in both the 2019/24 and 2021/24 panels (Tables 4.5a and Table 4.5b). The prevalence of fee schedules did not change significantly. Overall, more facilities had a fee schedule than posted it publicly for patients to see. In one instance, the percentage of HCs that posted their fee schedule publicly decreased significantly, from approximately 64 percent in 2019 to 54 percent in 2024 (Table 4.5a). There were no significant changes in the 2019/24 panel facilities (Table 4.5b).

Table 4.5a. Presence of fee schedules at health facilities, by survey round

	Matched panel				
	2019%	2021%	2024%	PP diff (2019 vs 2024)	p-value (2019 vs 2024)
Health centers (n=296)					
Fee schedule present	78.8	82.9	82.1	3.3	0.31
Fee schedule posted publicly	63.6	65.1	54.4	-9.3	0.02**
Hospitals (n=116)					
Fee schedule present	93.9	97.4	94.8	0.9	0.76
Fee schedule posted publicly	73.9	75.0	71.6	-2.4	0.69

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Table 4.5b. Presence of fee schedules at health facilities, by survey round

	Matched panel			
	2021%	2024%	PP diff (2021 vs 2024)	p-value (2021 vs 224)
Health centers (n=158)				
Fee schedule present	84.2	85.4	1.2	0.77
Fee schedule posted publicly	66.5	66.9	0.4	0.94
Hospitals (n=24)				
Fee schedule present	95.8	91.7	-4.2	0.55
Fee schedule posted publicly	83.3	66.7	-16.7	0.18

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Facilities were asked what they did in a case where a patient presented with an emergency condition or in labor but could not pay the fee upfront. The most common responses from HCs were strategies that promoted access: providing services at free or reduced cost, allowing patients to give a guarantee, and allowing patients to pay in-kind (Table 4.6a). Strategies that inhibited access were less common, but their use increased significantly. Refusing the patient services in the future increased from approximately 3 percent in 2019 to 13 percent in 2024, and not discharging patients until they paid increased from 9.8 percent to 15.2 percent. Similar increases were seen in the 2021/24 panel (Table 4.6b).

Table 4.6a. Health center strategies when patients could not pay for emergency and labor and delivery care, by survey round

	Matched panel (n=296)				
	2019%	2021%	2024%	PP diff (2019 vs 2024)	p-value (2019 vs 2024)
Strategies that promote access					
Services provided at free or reduced cost	56.9	54.5	52.7	-4.2	0.30
Patient can give a guarantee	46.5	50.7	50.0	3.5	0.39
Patient can pay in-kind	40.7	30.8	31.8	-9.0	0.02**
Nothing; no recourse	3.7	2.1	4.7	1.0	0.53
Strategies that inhibit access					
Patient is refused services in the future	2.7	1.4	13.2	10.5	<0.01***
Patient is not discharged until they pay	9.8	8.2	15.2	5.4	0.05**
No services are given	0.0	1.4	0.3	0.3	0.32

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Table 4.6b. Health center strategies when patients could not pay for emergency and labor and delivery care, by survey round

	Matched panel (n=158)			
	2021%	2024%	PP diff (2021 vs 2024)	p-value (2021 vs 224)
Strategies that promote access				
Services provided at free or reduced cost	56.3	60.5	4.2	0.45
Patient can give a guarantee	63.9	63.1	-0.9	0.87
Patient can pay in-kind	48.7	52.2	3.5	0.54
Nothing; no recourse	5.7	7.6	1.9	0.49
Strategies that inhibit access				
Patient is refused services in the future	3.2	15.3	12.1	<0.01***
Patient is not discharged until they pay	5.7	15.3	9.6	<0.01***
No services are given	2.5	2.6	0.0	0.99

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Hospitals also commonly employed strategies to promote access, and the percentage that allowed patients to give a guarantee increased significantly in the 2021/24 panel (Table 4.7b). However, the percentage of hospitals that would provide services at free or reduced cost decreased significantly from 2019 to 2024 (Table 4.7a). The practices of refusing future services and not discharging the patient until they paid increased significantly, with more than 30 percent of hospitals in the 2019/24 panel and 25 percent in the 2021/2024 panel refusing to discharge non-paying patients in 2024.

Table 4.7a. Hospital strategies when patients could not pay for emergency and labor and delivery care, by survey round

	Matched panel (n=116)				
	2019%	2021%	2024%	PP diff (2019 vs 2024)	p-value (2019 vs 2024)
Strategies that promote access					
Services provided at free or reduced cost	63.5	61.2	52.6	-10.9	0.09*
Patient can give a guarantee	41.7	50.0	45.7	4.0	0.55
Patient can pay in-kind	23.5	17.2	23.3	-0.2	0.97
Nothing; no recourse	3.5	2.6	8.6	5.1	0.10
Strategies that inhibit access					
Patient is refused services in the future	1.7	2.6	22.4	20.7	<0.01***
Patient is not discharged until they pay	16.5	24.1	30.2	13.7	0.01**
No services are given	0.0	0.9	0.0	0.0	N/A

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Table 4.7b. Hospital strategies when patients could not pay for emergency and labor and delivery care, by survey round

	Matched panel (n=24)			
	2021%	2024%	PP diff (2021 vs 2024)	p-value (2021 vs 224)
Strategies that promote access				
Services provided at free or reduced cost	70.8	62.5	-8.3	0.54
Patient can give a guarantee	33.3	58.3	25.0	0.08*
Patient can pay in-kind	29.2	29.2	0.0	1.00
Nothing; no recourse	4.2	0.0	-4.2	0.31
Strategies that inhibit access				
Patient is refused services in the future	4.2	12.5	8.3	0.30
Patient is not discharged until they pay	4.2	29.2	25.0	0.02**
No services are given	0.0	4.2	4.2	0.31

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Adequate Staffing Numbers and Mix According to Government Guidelines

Government guidelines state that rural HCs should have a minimum of four nurses (A1/A2), two midwives, one laboratory technician, and one maintenance technician. Urban HCs should have a minimum of eight nurses (A1/A2), four midwives, two laboratory technicians, and one maintenance technician.

When considering each cadre of health worker individually, HCs were most likely to have an adequate number of nurses. This was followed by maintenance technicians, laboratory technicians, and finally, midwives.

By 2024, 35 percent of HCs across six provinces with data from 2019 and 2024 reported having an adequate number of nurses according to government guidelines, an increase of 12.1 PPs from 2019—a statistically significant increase (Table 4.8a). Sud Kivu experienced a significant increase in nurse adequacy, rising by 16 PPs (p=0.033). Haut Katanga and Lualaba also saw non-significant increases. Sankuru reported a substantial,

although marginally non-significant rise from 42.5 percent to 62.5 percent between 2019 and 2024. Tanganyika saw a decrease of 3.82 PPs between 2019 and 2024, although it was not statistically significant. In the three provinces surveyed only in 2021 and 2024, overall nurse adequacy remained stable, with no significant changes observed in Kasai Central or Lomami, but a non-significant decrease was reported for Haut Lomami (Table 4.8b).

Table 4.8a. Health centers with an adequate number of nurses according to government guidelines, by province and survey round

		Matched Panel 2019 (n=301)	Matched Panel 2021 (n=297)	Matched Panel 2024 (n=297)		
		%	%	%	PP diff (2019 vs 2024)	p-value (2019 vs 2024)
Overall (6 provinces)		22.92	28.62	35.02	12.1	0.001***
Eastern Congo						
	Sud Kivu	37.93	43.68	54.02	16.09	0.033**
	Tanganyika	11.51	11.54	7.69	-3.82	0.638
Katanga						
	Haut Katanga	14.29	20.69	25.86	11.57	0.111
	Lualaba	11.43	5.71	22.86	11.43	0.205
Kasai						
	Sankuru	42.5	62.5	62.5	20	0.073*
	Kasai Oriental	6	10	12	6	0.295

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Table 4.8b. Health centers with an adequate number of nurses according to government guidelines, by province and survey round

		Matched Panel 2021 (n=158)	Matched Pane 2024 (n=134)		
		%	%	PP diff (2021 vs 2024)	p-value (2021 vs 2024)
Overall (3 provinces)		48.73	47.76	-0.97	0.868
Katanga					
	Haut Lomami	33.33	24.14	-9.19	0.418
Kasai					
	Kasai Central	60.81	61.29	0.48	0.951
	Lomami	41.67	44.19	2.52	0.808

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

The percentage of HCs with the recommended number of midwives is shown in Tables 4.9a and 4.9b. In 2024, 2.69 percent of HCs reported having an adequate number of midwives according to government guidelines, a minimal non-significant increase from 2.66 percent in 2019 (Table 4.9a). Sud Kivu and Sankuru saw a slight non-significant increase in midwife adequacy, and Haut Katanga and Lualaba experienced non-significant decreases. Across the provinces included from 2021 to 2024, there was an overall decline in midwife staffing adequacy, with a significant decrease observed at the overall level (Table 4.9b). Haut Lomami, Kasai Central, and Lomami all reported declines in midwife adequacy, although none of these were statistically significant.

Table 4.9a. Health centers with an adequate number of midwives according to government guidelines, by province and survey round

		Matched Panel 2019 (n=301)	Matched Panel 2021 (n=297)	Matched Panel 2024 (n=297)		
		%	%	%	PP diff (2019 vs 2024)	p-value (2019 vs 2024)
Overall (6 provinces)		2.66	1.01	2.69	0.03	0.978
Eastern Congo						
	Sud Kivu	4.6	0	6.9	2.3	0.515
	Tanganyika	0	0	0	0	---
Katanga						
	Haut Katanga	3.17	3.45	1.72	-1.45	0.608
	Lualaba	5.71	0	0	-5.71	0.151
Kasai						
	Sankuru	0	2.5	2.5	2.5	0.314
	Kasai Oriental	0	0	0	0	---

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Table 4.9b. Health centers with an adequate number of midwives according to government guidelines, by province and survey round

	Matched Panel 2021 (n=158)	Matched Panel 2024 (n=134)		
	%	%	PP diff (2021 vs 2024)	p-value (2021 vs 2024)
Overall (3 provinces)	9.49	3.73	-5.76	0.052*
Katanga				
Haut Lomami	5.56	0	-5.56	0.197
Kasai				
Kasai Central	10.81	4.84	-5.97	0.203
Lomami	10.42	4.65	-5.77	0.303

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

By 2024, 10.44 percent of HCs reported having an adequate number of laboratory technicians according to government guidelines, an increase of 3.13 PPs from 7.31 percent in 2019, although this change was not statistically significant (Table 4.10a). Sud Kivu and Haut Katanga saw slight non-significant increases. Sankuru and Kasai Oriental experienced notable improvements, with Sankuru showing a significant increase (p=0.021). Lualaba showed no change in adequacy levels and Tanganyika had no reports of laboratory technicians. In the provinces included from 2021 to 2024, there was a significant overall decrease in laboratory technician adequacy (Table 4.10b), with both Kasai Central and Lomami experiencing significant decreases (p=0.005 and p=0.029), and Haut Lomami reporting a non-significant decrease.

Table 4.10a. Health centers with an adequate number of laboratory technicians according to government guidelines, by province and survey round

	Matched Panel 2019 (n=301)	Matched Panel 2021 (n=297)	Matched Panel 2024 (n=297)		
	%	%	%	PP diff (2019 vs 2024)	p-value (2019 vs 2024)
Overall (6 provinces)	7.31	8.08	10.44	3.13	0.178
Eastern Congo					
Sud Kivu	12.64	10.34	13.79	1.15	0.823
Tanganyika	0	0	0	0	---
Katanga					
Haut Katanga	12.7	10.34	13.79	1.09	0.859
Lualaba	8.57	8.57	8.57	0	1
Kasai					
Sankuru	0	10	12.5	12.5	0.021**
Kasai Oriental	0	4	6	6	0.079*

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Table 4.10b. Health centers with an adequate number of laboratory technicians according to government guidelines, by province and survey round

		Matched Panel 2021 (n=158)	Matched Panel 2024 (n=134)		
		%	%	PP diff (2021 vs 2024)	p-value (2021 vs 2024)
Overall (3 provinces)		14.56	2.24	-12.32	0.000***
Katanga					
	Haut Lomami	5.56	0	-5.56	0.197
Kasai					
	Kasai Central	21.62	4.84	-16.78	0.005***
	Lomami	10.42	0	-10.42	0.029**

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Tables 4.11a and 4.11b display the percentage of HCs that had the recommended number of maintenance technicians on staff. Overall, 14.48 percent of HCs reported having an adequate number of maintenance technicians according to government guidelines, a significant increase of 10.83 PPs from 2019 (Table 4.11a). Sud Kivu, Tanganyika, and Kasai Oriental saw significant improvements in maintenance technician staffing adequacy. Haut Katanga also reported a modest, non-significant increase. For provinces only included in 2021 and 2024, overall maintenance technician adequacy slightly decreased, with a significant decrease in Haut Lomami (Table 4.11b). Kasai Central showed a significant increase and Lomami experienced a non-significant decrease.

Table 4.11a. Health centers with an adequate number of maintenance technicians according to government guidelines, by province and survey round

		Matched Panel 2019 (n=301)	Matched Panel 2021 (n=297)	Matched Panel 2024 (n=297)		
		%	%	%	PP diff (2019 vs 2024)	p-value (2019 vs 2024)
Overall (6 provinces)		3.65	6.06	14.48	10.83	0.000***
Eastern Congo						
	Sud Kivu	1.15	10.34	9.2	8.05	0.017**
	Tanganyika	0	11.54	26.92	26.92	0.004***
Katanga						
	Haut Katanga	9.52	3.45	15.52	6	0.318
	Lualaba	2.86	11.43	2.86	0	1
Kasai						
	Sankuru	0	0	0	0	---
	Kasai Oriental	6	0	34	28	0.000***

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Table 4.11b. Health centers with an adequate number of maintenance technicians according to government guidelines, by province and survey round

		Matched Panel 2021 (n=158)	Matched Panel 2024 (n=134)		
		%	%	PP diff (2021 vs 2024)	p-value (2021 vs 2024)
Overall (3 provinces)		21.52	19.4	-2.12	0.656
Katanga					
	Haut Lomami	36.11	3.45	-32.66	0.001***
Kasai					
	Kasai Central	20.27	35.48	15.21	0.047**
	Lomami	12.5	6.98	-5.52	0.378

Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01

Health Worker Attitudes

Health workers working at HCs were asked the degree to which they agreed with a set of statements about interactions with patients. The results are shown in Tables 4.12a and 4.12b. For HCs surveyed from 2019 to 2024, the vast majority (96.68%) continued to agree with the statement, “I consider my patients to be worthy of respect no matter how poor or low status they are”; however, there was a slight non-significant decline in this view (Table 4.12a). Significant improvements were observed in attitudes regarding patients' education and gratitude, with fewer health workers agreeing with the statement, “Patients I care for are not educated enough to make good health decisions for themselves” or “Patients I care for are not grateful for the efforts I make when I care for them.” However, there was a slight, 2.41 PP increase in the percentage of health workers who agreed with the statement ,“Patients often treat me without respect, so it’s hard to treat them with respect.” There was a notable decrease in agreement with the statement that “Patients I care for make bad decisions regarding their health no matter what I tell them.” Overall, most attitudes remained stable in the provinces surveyed only in 2021 and 2024 (Table 4.12b).

Table 4.12a. Health center-based health worker attitudes toward patients, by survey round

	Matched Panel 2019 (n=1073)	Matched Panel 2021 (n=1024)	Matched Panel 2024 (n=1143)		
	%	%	%	PP diff (2019 vs 2024)	p-value (2019 vs 2024)
Patients I care for are not educated enough to make good health decisions for themselves (-)	56.66	47.85	49.61	-7.05	0.003***
Patients I care for are not grateful for the efforts I make when I care for them (-)	38.49	33.2	31.41	-7.08	0.002***
I consider my patients to be worthy of respect no matter how poor or low status they are (+)	97.58	97.17	96.68	-0.9	0.327
Patients often treat me without respect, so it’s hard to treat them with	6.34	9.96	8.75	2.41	0.011**

	Matched Panel 2019 (n=1073)	Matched Panel 2021 (n=1024)	Matched Panel 2024 (n=1143)		
	%	%	%	PP diff (2019 vs 2024)	p-value (2019 vs 2024)
respect (-)					
Patients I care for make bad decisions regarding their health no matter what I tell them (-)	28.8	20.9	21.52	-7.28	0.000***
Engaging patients in discussions leads to better health outcomes than just telling them what is best for them (+)	90.31	85.84	87.75	-2.56	0.101
My patients will work hard to improve their health when they are given the proper information (+)	90.03	92.77	89.15	-0.88	0.188
Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01					

Table 4.12b. Health center-based health worker attitudes toward patients, by survey round

	Matched Panel 2021 (n=460)	Matched Panel 2024 (n=496)		
	%	%	PP diff (2019 vs 2024)	p-value (2019 vs 2024)
Patients I care for are not educated enough to make good health decisions for themselves (-)	52.83	54.84	2.01	0.744
Patients I care for are not grateful for the efforts I make when I care for them (-)	40.43	40.93	0.5	0.647
I consider my patients to be worthy of respect no matter how poor or low status they are (+)	97.83	95.77	-2.06	0.111
Patients often treat me without respect, so it's hard to treat them with respect (-)	14.35	11.29	-3.06	0.359
Patients I care for make bad decisions regarding their health no matter what I tell them (-)	20.87	20.56	-0.31	0.827
Engaging patients in discussions leads to better health outcomes than just telling them what is best for them (+)	81.3	81.05	-0.25	0.000***
My patients will work hard to improve their health when they are given the proper information (+)	86.96	85.08	-1.88	0.451
Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01				

Health workers working at HCs were also asked the degree to which they agreed with a set of statements about their roles (Tables 4.13a and 4.13b). By the 2024 survey, health workers showed mixed attitudes toward their roles compared with previous years. There was a significant increase in the percentage of health workers who agreed with the statement, "I do not spend a lot of thought about what patients may think about their experience at the clinic as I have other things to worry about," rising by 2.91 PPs to 12.86 percent (Table 4.13a). In addition, more health workers agreed with the statement, "My job is to diagnose and treat patients, not to be a health educator," with this view increasing significantly by 5.2 PPs. For HCs in provinces only included in 2021 and 2024, a significant decrease was observed in those who agreed with the statement, "I try hard to think about all of the patients' healthcare needs not just solving their immediate problem," declining by 7.46 PPs (Table 4.13b).

Table 4.13a. Health center-based health worker attitudes toward their roles, by survey round

	Matched Panel 2019 (n=1055)	Matched Panel 2021 (n=1024)	Matched Panel 2024 (n=1143)		
	%	%	%	PP diff (2019 vs 2024)	p-value (2019 vs 2024)
My role is to provide clinical care, not to teach patients about how to take care of themselves (-)	18.77	20.9	19.86	1.09	0.476
I do not spend a lot of thought about what patients may think about their experience at the clinic as I have other things to worry about (-)	9.95	13.87	12.86	2.91	0.002***
An important part of my job is to communicate with patients to make sure they understand their care (+)	95.36	96.48	95.71	0.35	0.898
I try hard to think about all of the patients' healthcare needs not just solving their immediate problem (+)	85.78	84.96	83.81	-1.97	0.382
I was trained to provide clinical care, being respectful to every patient is not my job (-)	25.02	26.56	29.22	4.2	0.086*
When medicine is given, it is important that I explain well what it does for the patient and how it helps them (+)	97.25	98.63	97.46	0.21	0.098*
I think it is important to spend enough time with each patient, even if I have other job demands (+)	85.31	90.04	89.5	4.19	0.008***
My job is to diagnose and treat patients not to be a health educator (-)	7.49	12.4	12.69	5.2	0.000***
Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01					

Table 4.13b. Health center-based health worker attitudes toward their roles, by survey round

	Matched Panel 2021 (n=460)	Matched Panel 2024 (n=496)		
	%	%	PP diff (2019 vs 2024)	p-value (2019 vs 2024)
My role is to provide clinical care, not to teach patients about how to take care of themselves (-)	26.74	21.17	-5.57	0.117
I do not spend a lot of thought about what patients may think about their experience at the clinic as I have other things to worry about (-)	19.13	14.52	-4.61	0.131
An important part of my job is to communicate with patients to make sure they understand their care (+)	95	93.15	-1.85	0.224
I try hard to think about all of the patients' healthcare needs not just solving their immediate problem (+)	80.65	73.19	-7.46	0.011**
I was trained to provide clinical care, being respectful to every patient is not my job (-)	31.3	24.8	-6.5	0.056*
When medicine is given, it is important that I explain well what it does for the patient and how it helps them (+)	97.83	98.19	0.36	0.747
I think it is important to spend enough time with each patient, even if I have other job demands (+)	93.26	89.31	-3.95	0.047**
My job is to diagnose and treat patients not to be a health educator (-)	19.35	16.13	-3.22	0.105
Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01				

Health Workers Experiencing Threats

Health workers working at HCs were asked whether they have experienced threats or verbal abuse from a patient or patient's family. The results are shown in Tables 4.14a and 4.14b. Overall, 14.44 percent of health workers across six provinces reported experiencing threats or verbal abuse from patients or their families, showing no significant change from 2019 (Table 4.14a). Haut Katanga and Kasai Oriental saw notable, although non-significant, increases in reported incidents, with Haut Katanga rising by 5.28 PPs and Kasai Oriental by 6.37 PPs. However, Sankuru experienced a significant decrease in such incidents, dropping by 9.58 PPs (p=0.021). For provinces included from 2021 to 2024, there was a significant overall increase in reported abuse (Table 4.14b). Lomami reported that the percentage of health workers experiencing threats or verbal abuse increased by 11.06 PPs from 2021 to 2024.

Table 4.14a. Health workers who have experienced threats or verbal abuse from a patient or patient's family, by province and survey year

	Matched Panel 2019 (n=1055)	Matched Panel 2021 (n=1006)	Matched Panel 2024 (n=1129)		
	%	%	%	PP diff (2019 vs 2024)	p-value (2019 vs 2024)
Overall (6 provinces)	14.03	12.92	14.44	0.41	0.785
Eastern Congo					
Sud Kivu	9.36	11.38	7.36	-2	0.365
Tanganyika	16.09	11.39	12.96	-3.13	0.536
Katanga					
Haut Katanga	17.29	19.1	22.57	5.28	0.167
Lualaba	11.3	11.93	16	4.7	0.291
Kasai					
Sankuru	20	10.83	10.42	-9.58	0.021**
Kasai Oriental	13.33	12.44	19.7	6.37	0.097*
Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01					

Table 4.14b. Health workers who have experienced threats or verbal abuse from a patient or patient's family, by province and survey year

		Matched Panel 2021 (n=446)	Matched Panel 2024 (n=473)		
		%	%	PP diff (2021 vs 2024)	p-value (2021 vs 2024)
Overall (3 provinces)		10.31	16.7	6.39	0.005***
Katanga					
	Haut Lomami	12.15	15.83	3.68	0.426
Kasai					
	Kasai Central	13.73	16.48	2.75	0.488
	Lomami	6.45	17.51	11.06	0.001***
Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01					

HC workers were also asked about experiencing physical violence (slapping, hitting, punching) by patients or their families (Tables 4.15a and 4.15b). For health workers in provinces included from 2019 to 2024, 3.21 percent reported experiencing physical violence from patients or their families, a slight but non-significant increase from 2.65 percent in 2019 (Table 4.15a). Tanganyika saw a statistically significant increase in reported incidents, increasing by 7.05 PPs, whereas Sankuru experienced a significant decrease, with reports dropping by 4.9 PPs. Sud Kivu, Haut Katanga, Lualaba, and Kasai Oriental showed non-significant changes. The provinces included from 2021 to 2024 saw a non-significant overall increase in reported incidents of physical violence, with Haut Lomami showing a marginally significant increase of 3.31 PPs (Table 4.15b).

Table 4.15a. Health workers who have experienced physical violence (slapping, hitting, punching) from a patient or patient's family, by province and survey year

		Matched Panel 2019 (n=1058)	Matched Panel 2021 (n=1014)	Matched Panel 2024 (n=1121)		
		%	%	%	PP diff (2019 vs 2024)	p-value (2019 vs 2024)
Overall (6 provinces)		2.65	2.27	3.21	0.56	0.435
Eastern Congo						
	Sud Kivu	2.01	1.03	1.55	-0.46	0.665
	Tanganyika	2.3	3.66	9.35	7.05	0.043**
Katanga						
	Haut Katanga	3.69	5.52	4.41	0.72	0.701
	Lualaba	0.87	0.93	2.46	1.59	0.342
Kasai						
	Sankuru	5.59	0.63	0.69	-4.9	0.017**
	Kasai Oriental	1.12	2.59	3.57	2.45	0.121
Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01						

Table 4.15b. Health workers who have experienced physical violence (slapping, hitting, punching) from a patient or patient's family, by province and survey year

		Matched Panel 2021 (n=452)	Matched Panel 2024 (n=473)		
		%	%	PP diff (2021 vs 2024)	p-value (2021 vs 2024)
Overall (3 provinces)		2.88	4.65	1.77	0.157
Katanga					
	Haut Lomami	0	3.31	3.31	0.057*
Kasai					
	Kasai Central	6.33	6.86	0.53	0.846
	Lomami	1.61	3.39	1.78	0.276
Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01					

RECO Involvement in Community-Based Distribution of Family Planning

Questions concerning RECO groups were not asked in 2019 and, as such, comparisons are made between survey time points collected in 2021 and 2024. The surveyed RECOs were asked several questions about FP activities.

By the 2024 survey, 57.98 percent of RECOs reported involvement in the community-based distribution of contraceptives, showing a slight non-significant increase from 56.53 percent in 2021 (Table 4.16). Haut Katanga, Haut Lomami, Lualaba, Sankuru, and Lomami saw increases in involvement. Haut Katanga increased by a statically significant 17.23 PPs. Tanganyika and Kasai Central experienced significant decreases in RECO involvement in community-based distribution of contraceptives, with Tanganyika decreasing by 21.22 PPs and Kasai Central by 11.12 PPs.

Findings related to RECOs involved in community member sensitization on FP methods are found in Table 4.17. By the 2024 survey, the involvement of RECOs in community member sensitization on FP methods decreased to 86.46 percent from 87.74 percent in 2021. Tanganyika and Kasai Oriental saw a non-statistically significant increase in sensitization efforts. Kasai Central experienced a significant decrease in involvement, dropping by 7.98 PPs (p=0.006). Lualaba and Sankuru also observed decreases of 9.46 PPs and 6.92 PPs, respectively.

Information on RECOs reporting involvement in FP mini-campaigns over the past 12 months was collected (Table 4.18). By 2024, 71.65 percent of RECOs reported involvement in FP mini-campaigns, reflecting a slight non-significant decrease from 73.03 percent in 2021. Sud Kivu showed a non-significant increase in participation, whereas Tanganyika experienced a decrease of 15.38 PPs, approaching statistical significance (p=0.081). Sankuru and Lomami showed a non-significant increase of 17.36 and 10.38 PPs, respectively. Kasai Central saw a significant drop of 13.65 PPs in RECO involvement (p=0.031) whereas other regions, such as Haut Katanga, Haut Lomami, and Lualaba, experienced non-significant decreases.

Table 4.16 RECOs involved in community-based distribution of FP (community-based distribution of contraceptives), by province and survey year

		Matched Panel 2021 (n=987)	Matched Panel 2024 (n=1071)		
		%	%	PP diff (2021 vs 2024)	p-value (2021 vs 2024)
Overall (9 provinces)		56.53	57.98	1.45	0.507
Eastern Congo					
	Sud Kivu	51.81	46.53	-5.28	0.294
	Tanganyika	70.37	49.15	-21.22	0.022**
Katanga					
	Haut Katanga	45.64	62.87	17.23	0.002***
	Lualaba	52.05	59.52	7.47	0.347
Kasai					
	Sankuru	46.81	57.14	10.33	0.152
	Kasai Oriental	55.36	48.67	-6.69	0.316
Katanga					
	Haut Lomami	55.07	68.09	13.02	0.09*
Kasai					
	Kasai Central	82.64	71.52	-11.12	0.022**
	Lomami	51.52	57.29	5.77	0.418
Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01					

Table 4.17. RECOs involved in community-based distribution of FP (community member sensitization on FP methods), by province and survey year

		Matched Panel 2021 (n=987)	Matched Panel 2024 (n=1071)		
		%	%	PP diff (2021 vs 2024)	p-value (2021 vs 2024)
Overall (9 provinces)		87.74	86.46	-1.28	0.387
Eastern Congo					
	Sud Kivu	88.6	89.6	1	0.749
	Tanganyika	72.22	86.44	14.22	0.061*
Katanga					
	Haut Katanga	85.91	83.23	-2.68	0.512
	Lualaba	90.41	80.95	-9.46	0.095*
Kasai					
	Sankuru	94.68	87.76	-6.92	0.091*
	Kasai Oriental	84.82	92.92	8.1	0.053*
Katanga					
	Haut Lomami	78.26	80.85	2.59	0.684
Kasai					
	Kasai Central	97.22	89.24	-7.98	0.006***
	Lomami	84.85	82.29	-2.56	0.63
Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01					

Table 4.18. RECOs involved in community-based distribution of FP (involved with a FP mini-campaign in the past 12 months), by province and survey year

		Matched Panel 2021 (n=482)	Matched Panel 2024 (n=589)		
		%	%	PP diff (2021 vs 2024)	p-value (2021 vs 2024)
Overall (9 provinces)		73.03	71.65	-1.38	0.615
Eastern Congo					
	Sud Kivu	71.43	76.92	5.49	0.367
	Tanganyika	100	84.62	-15.38	0.081*
Katanga					
	Haut Katanga	76.7	68.37	-8.33	0.185
	Lualaba	70.45	65.85	-4.6	0.649
Kasai					
	Sankuru	47.22	64.58	17.36	0.112
	Kasai Oriental	68.52	68.49	-0.03	0.998
Katanga					
	Haut Lomami	71.43	61.11	-10.32	0.431
Kasai					
	Kasai Central	88.89	75.24	-13.65	0.031**
	Lomami	65.38	75.76	10.38	0.275
Statistical significance is considered at *p<0.1, **p<0.05, and ***p<0.01					

A summary of key service delivery indicators is shown in Table 4.19. The table characterizes performance as of the 2024 survey, the direction of change between survey waves, and indicates whether the difference is statistically significant.

Table 4.19. Summary of service delivery indicators

Indicator	Performance (2024)	Direction (2019 vs 2024 unless indicated)
Hospital-based workers who correctly included preeclampsia in their differential diagnosis in the clinical vignette	Mid-strong	↓*
Health center-based workers who correctly included shigella/dysentery in their differential diagnosis in the clinical vignette	Mid-strong	↑*
Hospital-based workers who correctly included shigella/dysentery in their differential diagnosis in the clinical vignette	Strong	↑*
Health center-based workers who offered contraception in the clinical vignette	Mid-strong	↑*
Hospital-based workers who offered contraception in the clinical vignette	Mid-strong	↑
Health centers with a standard fee schedule	Strong	↑
Hospitals with a standard fee schedule	Strong	→
Health centers with adequate numbers of nurses	Mid-poor	↑*
Health centers with adequate numbers of midwives	Poor	→
Health centers with adequate numbers of laboratory technicians	Poor	↑
Health centers with adequate numbers of maintenance technicians	Poor	↑*
Health workers who have experienced threats or verbal abuse from a patient or patient's family (strong performance = low incidence)	Strong	→
Health workers who have experienced physical violence (slapping, hitting, punching) from a patient or patient's family (strong performance = low incidence)	Strong	→
RECOs involved in community-based distribution of contraceptives (2021 vs 2024)	Mid-strong	↑
RECOs involved in community member sensitization on family planning methods (2021 vs 2024)	Strong	↓
RECOs involved in a family planning mini-campaign (2021 vs 2024)	Mid-strong	↓

Notes: Strong= 75%–100% of respondents; Mid-Strong= 50%–74% of respondents; Mid-Poor=25%–49% of respondents; Poor=0%–24% of respondents overall in 2024. Arrows indicate the direction of change between 2019 and 2024 in the matched panel. * indicates that the change was statistically significant at p<0.1. Indicators related to health worker attitudes are omitted because they are contextual and cannot be categorized as "strong versus poor performance."

Qualitative Results

Sud Kivu Province: Key Informant Perspectives

Introduction

Sud Kivu province was established in 1989 when the Kivu province was divided into three provinces. The DPS offices have been functioning for decades. Sud Kivu is comprised of 34 HZs, 18 of which are included in USAID corridors (focal USAID areas) where other USAID partners implement activities. The HZs in our evaluation—Miti Murhesa and Walungu, which are in USAID corridors—were also included in the midline evaluation. It should be noted that Breakthrough ACTION (BA) piloted the VIVA campaign in the Walungu HZ.

Since 2022, key informants noted a sharp decline in USAID IHP-sponsored activities. The USAID IHP informant reported that in 2022, in conjunction with the DPS, USAID IHP developed a 6 million USD budget to support Sud Kivu health systems, which was later reduced to between 1 and 2 million USD. He also mentioned that in 2022, USAID IHP had to temporarily stop activities and was unable to follow the planned calendar due to budget constraints. Subsequently, USAID IHP had to prioritize activities and reduce the number of targeted HZs from five to three, with other implementing partners (IPs) taking up interventions originally planned for USAID IHP. Key informants added that USAID IHP staff had much less of a presence in the field. The Médecin Chef de Zone (MCZ; Chief Medical Officer) in Walungu reported a sharp decline in assistance, especially in 2023, when he claimed that USAID IHP did not offer any support, adding that their absence had had a negative effect on planned achievements in 2023. The Miti Murhesa MCZ also indicated that USAID IHP assistance had become sporadic since 2022, affecting operational plans. It should be noted that USAID IHP developed a sustainability plan that delineated government implementation of USAID IHP activities once project support ended.

The following sections describe key informants' accounts of USAID IHP activities according to program objectives in the Sud Kivu province.

Objective 1: Strengthen Health Systems, Governance, and Leadership at Provincial, Health Zone, and Facility Levels in Target Health Zones

Key informants reported that USAID IHP supported individual and institutional capacity building through a variety of activities, including the PICAL assessment; the development and monitoring of the annual operational plan; training sessions; supervision; routine management and technical review meetings at the DPS, HZ, and HA levels; and other technical meetings, like the weekly surveillance task force group meeting. The PICAL assessment was cited as a useful tool to examine institutional leadership and management capacity and identify ways to address weaknesses, leading to more harmonious work settings. However, key informants mentioned that the PICAL assessment was not carried out as regularly as planned, with the informant from Walungu HZ mentioning applying the PICAL tool only twice since the start of the program. USAID IHP and DPS informants noted that during the first three years, the program invested in extensive training designed to improve capacity related to leadership, management, and planning. However, financial management training was not conducted. After the midline evaluation, the program's focus was on monitoring to ensure that capacity strengthening efforts continued. Informants praised USAID IHP support for the development of the annual and quarterly workplans, with the DPS informant noting that USAID IHP was the only organization that assisted with annual planning, thus ensuring coordination and timely execution of

activities. Informants also underlined the importance of the USAID IHP-supported review meetings, which they considered essential to the functioning of the DPS and *Bureau central de la zone de santé (*BCZS, central office of the HZ) as well as supervisory visits. However, BCZS informants mentioned that financial assistance for supervision had been reduced to support three rather than five supervisors monthly at 50 USD per month. One MCZ noted that with USAID IHP assistance, the quality of meetings and supervision visits had improved. The USAID IHP representative expressed frustration with officials representing DPS programs' unwillingness to take ownership of supervision visits, stating that the motorcycles that USAID IHP had provided to the DPS were not used for supervision in urban settings when transport payments were not offered.

According to key informants, accountability mechanisms were improving transparency and decreasing fraud, with all informants noting the impact of the "greenline" (anti-fraud/corruption hotline), which with USAID IHP support was available across all 34 HZs. USAID IHP was supporting the *Inspection Provinciale de la Santé* (IPS, Provincial Health Inspectorate) to monitor calls made through the greenline and carry out audits to identify irregularities related to health practices, embezzlement, and other corrupt practices, and to implement penalties for infractions. However, the USAID IHP representative noted that financial limitations did not allow USAID IHP to carry out audits in all 34 HZs. Informants reported that sanctions and suspensions resulting from investigations of fraudulent activities had increased. As part of the package of assistance, USAID IHP had provided information kits, including laptops, printers, and modems, to the IPS office to maintain the greenline system and respond to alerts, and had allocated funds to carry out regular monitoring visits to identify non-conformities in health-related practices and correct problems. One MCZ noted that the primary healthcare training led by USAID IHP had improved human resources, financial and material management, and transparency at the HA level. The MCZs generally appreciated the use of mobile money to transmit payments, which ensured that individuals received payment due to them. The MCZ from Miti Murhesa also reported that USAID IHP-supported implementation of the community scorecard approach had helped ensure that health workers were more accountable to their communities, whereas in Walungu, community scorecards had been introduced by another IP.

Informants noted that the number of medications delivered by USAID IHP had declined significantly from the start of the program. Informants reported numerous challenges related to drug distribution, mentioning that drugs were typically delivered late and in insufficient quantities to meet population needs, including malaria medications, with some explaining that drug requisitions were often not honored. Problems with drug deliveries were attributed to the late submission by HZs of requisitions, and that the HZs maintained insufficient capital to replenish stocks. The DPS representative and HZ informants included in the evaluation were not yet using the InfoMED software to monitor drug stocks, and the DPS informant added that more training was needed on the management of drug supplies. He also mentioned that the DPS and Regional Distribution Centers (*Centre de Distribution Régionale*; CDR) often had conflict related to the money maintained in the HZ accounts.

In 2022, USAID IHP distributed equipment to 110 health facilities of the 1,000 provincial facilities, with the selection of recipient facilities developed by the DPS. Selection criteria included structures with high treatment service use, constructed of durable materials, that had not yet received equipment from USAID or other IPs, and having the required number of health personnel. The equipment provided to hospitals included a range of critical materials (beds, cabinets, equipment for operating rooms, oxygen concentrators, microscopes, sterilization equipment, a range of equipment for hospital maternities, etc.), whereas the HCs

received essential supplies for basic treatment. Informants agreed that the equipment positively impacted quality of care and increased service demand at recipient health facilities. The two MCZ criticized USAID IHP for directly delivering the equipment to the facilities, adding that they were unaware of what equipment was delivered and, therefore, were unable to monitor the equipment. A MCZ in the lower-performing HZ lamented that only 14 of 26 HZ structures had received equipment. Because the program did not have adequate funds to provide equipment to all HCs, the plan was always to select a sample of health facilities based on criteria developed by the staff and government officials.

Government representatives raised concerns about theft, especially after USAID IHP activities were discontinued, although the USAID IHP informant mentioned that the DPS and IPS had a list of equipment that they were monitoring. Around the same time as the distribution of equipment, the DPS and all BCZS offices, as well as the IPS received two motorcycles for supervisory visits. USAID IHP also provided information kits, including computers, printers, and Internet modems, to the BCZS offices and to some HCs.

Informants agreed that USAID IHP assistance focused on data quality involving training, monthly monitoring reviews, delivery of modems, and provision of Internet credit (50 USD per month), which had improved data management and quality in terms of data completeness, timeliness, and precision, with the USAID IHP representative mentioning that data timeliness and completeness went from 21 percent to 97 percent between 2019 and 2024. A DPS representative said:

> *PROSANI [USAID IHP] contributed a lot. I can say that today we have quality data in the DHIS2 with zero rules violated, this is due to the support of PROSANI. Look at the reviews, data analysis with the data manager, quarterly reviews with the Chief Medical Officer of the zones. We have really improved the quality of data with funding from PROSANI.*

One MCZ mentioned that the monthly monitoring meetings helped zonal personnel understand what was not working and how to target supervision visits. Both HZs reported that with USAID IHP assistance, they had started to equip some HCs to enter their data in the DHIS2 system.

Informants reported that USAID IHP provided support for the revitalization of CACs and CODESA groups and gave 10 USD per month for regular CAC and CODESA committee meetings. However, around the time of our evaluation, the mandate of the CODESA and CAC committees had been completed, and there was concern about support for subsequent elections of RECOs and CODESA members. Several informants expressed concern about the motivation of RECOs, who they reported were abandoning work in large numbers. When talking about RECO motivation, the USAID IHP representative said:

> *Motivation is a big challenge, beyond their community activities, they must work. They say, well, I'm not motivated, my children are studying, and I have to feed my wife and family, and they leave, they get discouraged.*

A DPS informant said:

> *Community participation is very important, but it poses a problem because RECOs today are no longer interested in working for free, it is no longer the same RECOs who we knew as volunteers. The RECO come with intentions of interest [to get rewarded]. So, we also need to think about how to motivate these RECOs, how to retain the RECOs*

There was also mention of the need for additional training of both CODESA members and RECOs, who key

informants mentioned often lacked good understanding of key health themes, such as the different vaccines offered and the vaccine calendar, or ways to prevent common childhood diseases. Key informants reported increased numbers of women involved in leadership positions at the community level, as well as improvements in the participation of youth, especially in mass activities, such as campaigns involving vaccination administration or bed net distribution, when they could earn money by assisting with preparations or the distribution of materials. Others mentioned community health activities supported by USAID IHP, including mini-campaigns, international health days, and the VIVA approach, which MCZs said were being scaled up in HZs with limited support. The Miti Murhesa MCZ indicated that the VIVA approach was implemented in 6 of 18 HAs and few people had been trained. Informants also mentioned that economic growth activities were being implemented with assistance from the Ukraine supplemental funds. Since the midline evaluation, more iCCM sites were in place, with 288 across the province, including five to six sites in Walungu, but no sites were in Miti Murhesa.

Informants indicated that most health workers in Sud Kivu did not receive salary or government bonuses, and relied on facility revenue for payment. There was agreement that health workers were poorly paid and that there was little opportunity for the advancement of workers. The USAID IHP representative indicated that the program had contributed to motivation by providing training, equipment, and medicines, and that activities involving payment, such as supervision and training, also motivated workers. The attrition of workers continued to present a problem, especially after health workers received training that improved their skill sets. Some informants mentioned that recent government reforms mandating that provincial health workers be recruited by the MOH at the central level should help reduce the problem of recruitment based on political affiliation. Key informants reported that a few unqualified, A3 workers[2] were in the province, with one MCZ informant stating that the hiring process followed government criteria. The iHRIS had not been established in Sud Kivu, according to key informants.

USAID IHP provided extensive support for technical and review meetings at the DPS, BCZS, and HA levels. Key informants considered these meetings critical to the coordination, organization, and timely implementation of activities. A DPS representative appreciated the introduction of the unique contract because it helped coordinate and avoid duplication of work by IPs. A DPS informant expressed frustration that MCZs were more often in Bukavu rather than in their respective HZs, affecting their ability to participate in meetings. The MCZ from Miti said that USAID IHP continued to support program review meetings, like for malaria and immunization, whereas in the lower performing health zone (LPHZ), these meetings were financed by other IPs. There was agreement that USAID IHP staff were much less present at meetings than before the mid-line evaluation.

Contextual factors mentioned that affected activities included militia groups causing insecurity, especially in HZs bordering on North Kivu, and torrential rains causing landslides. Key informants also indicated that limited access to isolated HZs, some of which could only be reached by plane, posed significant challenges.

[2] A mechanism used at the provincial level to formalize financial and activity commitments by IPs and government partners.

Objective 2: Increase Access to Quality, Integrated Health Services in Target Health Zones

Malaria

Informants reported training on malaria diagnosis, treatment, counseling, and prevention in 2021, as well as separate training sessions on the rapid malaria test and laboratory work related to the detection of malaria. They mentioned that USAID IHP continued to provide regular supplies of malaria treatment medications, including artemisinin-based combination therapy (ACT), rapid tests, Fansidar for pregnant women attending ANC appointments, and bed nets, as well as flowcharts and consultation forms for malaria detection and treatment. There was also mention of supervision by DPS teams of malaria treatment using the Health Network Quality Information System tool, along with coaching, whereas supervision by the BCZS team was integrated. Informants added that USAID IHP supported malaria review meetings, although these meetings were not held in Walungu HZ in 2023. In Sud Kivu, USAID IHP provided bed nets to nine HZs during *consultation prenatale* (CPN; prenatal consultation) and *consultation préscolaire* (CPS; preschool consultation/well-child visits). In the Walungu HZ, there was mention of mass distribution of bed nets in 2022. In Sud Kivu, 288 iCCM sites had been set up using malaria and nutrition funds. Key informants reported a reduction in malaria cases, which they attributed to the ongoing availability of anti-malaria drugs, tests, and bed nets.

Maternal and Child Health

Maternal health has been a focus in Sud Kivu, where health workers received extensive training lasting two to three weeks on comprehensive emergency obstetric and newborn care (CEmONC) involving C-sections and other surgical procedures. USAID IHP set up two maternity centers of excellence in the province and a fistula repair center in Kaziba. USAID IHP also offered basic emergency obstetric and newborn care (BEmONC) and integrated management of childhood illness (IMCI) training to HC workers, as well as training on emergency neonatal and pediatric care to doctors in some hospital settings. The MCZs interviewed mentioned that SONU (EmONC, in English) training was provided in 2021 and did not include recently recruited midwives, and that refresher training was needed for both SONU B (basic EmONC, in English) and IMCI. USAID also provided partograms and IMCI flowcharts, data collection tools, and equipment for maternity and pediatric care to hospitals and HCs. However, the Walungu MCZ mentioned that the hospital still lacked adequate equipment in the maternity, neonatal, and surgical wards for emergency care. USAID IHP supported quarterly clinical mentoring by DPS officials of health workers who had been trained in obstetric and neonatal care, although informants reported that more clinical training was needed to provide quality supervision. Informants also mentioned that USAID IHP supported committees investigating maternal and perinatal deaths. However, in the Walungu HZ, key informants reported that committee members had lost motivation because they were not being reimbursed for transport and groups did not meet as planned. Informants reported that funds for supervision sometimes arrived late, disrupting the calendar, and that drugs for MCH were delivered irregularly after long intervals.

Nutrition

USAID IHP received supplementary funds in 2022 to support activities focused on food security and nutrition in four HZs; before 2022, nutrition interventions supported by USAID IHP were minimal. Activities included training of health workers on prevention and treatment of malnutrition, establishment of IYCF groups, culinary demonstrations, promotion of gardening and raising small animals, distribution of seeds for planting

of crops, and promotion of income generating activities. The HZs evaluated during the endline did not receive support from the supplementary funds but were getting assistance from other IPs on the prevention and treatment of malnutrition. However, the Miti Murhesa HZ reported receiving some support from USAID IHP for nutrition groups in five HAs. The USAID IHP representative mentioned that the nutrition program failed to carry out supervision visits and to take ownership of activities, and that the World Bank withdrew financial assistance due to their poor performance in the province.

Family Planning

Assistance has involved training health workers in contraceptive methods and counselling, with a focus on modern methods. However, since the midline evaluation, other USAID-funded IPs were overseeing the training. USAID IHP supported quarterly distribution of FP methods, which were free at HCs; awareness raising led by RECOs; the distribution of methods (e.g., pills, ovulation necklace); and counselling at the community level, with RECOs referring community members in need of long-acting methods to the HC. The USAID IHP representative reported occasional stockouts of contraceptive methods. An innovative approach had been to train and involve students in local nursing institutions in the distribution of methods at the community level. Informants reported increased use of contraceptives since the midline evaluation, which some mentioning that mini-campaigns had helped generate demand. A lower-performing health area (LPHA) reported receiving FP assistance from a different USAID-supported IP.

Tuberculosis

USAID IHP had established a contract with a local NGO to lead the identification of TB cases through mini-campaigns and household visits, the transport of samples collected from suspected cases, and oversight of treatment compliance at the community level. USAID IHP support also involved training workers and the provision of equipment, such as microscopes to screening centers, and the provision of free medications to TB patients, including resistant cases who were monitored by physicians. The program also financed supervision by the TB program, quarterly review meetings involving all 34 HZs, and a motorcycle to carry out supervisory visits. However, informants reported that TB supervision was irregular. The BCZS informant from Miti Murhesa reported receiving support for the transport of samples, detection of cases, and treatment of confirmed cases, including nutrition support for multi drug-resistant cases, whereas the Walungu MCZ was not receiving USAID IHP assistance for TB activities.

Vaccines

In Sud Kivu, USAID IHP transported vaccines to six HZs inaccessible by road, and the United Nations Children's Fund (UNICEF) delivered vaccines to the other HZs. The project recently provided 12 refrigerators with solar kits to HCs. USAID IHP also supported community efforts involving RECOs to identify and encourage children who had missed a vaccine or had not been vaccinated to come to the HC, especially in HZs where vaccination coverage was low. The project supported vaccine program supervisory visits and quarterly and annual vaccine meetings. Reported challenges included regular stockouts of the BCG vaccine and occasional stockouts of the measles vaccine, refusals by parents concerned about negative vaccine side effects, and maintaining the appropriate temperature for the cold chain, which the USAID IHP representative mentioned led to a recent epidemic of measles in all 34 HZs. The same informant reported that Sud Kivu continued to have high rates of children with zero dose. The USAID IHP representative complained that the vaccine program staff often failed to carry out supervision visits or to deliver vaccines to HZs as planned. He reported that although vaccine coverage had improved, they still faced major challenges ensuring that children were fully vaccinated. The

MCZ from the Walungu HZ reported not receiving assistance from USAID IHP related to vaccines since 2021, except for a mini-campaign that was held about three months before the endline evaluation. By contrast, the informant from the Miti Murhesa HZ reported that USAID IHP assistance had influenced improvements in the maintenance of the cold chain and the identification of children who had not been vaccinated, adding that coverage was increasing. HZ informants requested training of more BCZS supervisors, regular receipt of all vaccines, and training of health workers on immunizations. The informant from the Walungu HZ also cited the need for CPS revitalization.

Quality Assurance

The USAID IHP representative stated that integrated quality of care assessments had not been carried out at facilities as planned, and that quality assessments of the data collected at facilities had not been included in the recent annual workplan. There had been efforts focused on improving the quality of supervisory visits, although some BCZS-level informants mentioned that staff leading integrated supervision were not adequately trained on all themes. Zonal-level informants mentioned that primary healthcare training provided by USAID IHP, as well as training on IMCI, were critical to improving quality of care, but noted that quality of care assessments were needed. Both HZ informants mentioned that many health structures lacked adequate space to meet government standards.

Referral Systems

Informants agreed that USAID IHP had not worked to improve referrals of sick patients, which informants agreed did not function well. Informants mentioned several challenges, including poor motivation of CHWs, limited training of RECOs on the identification of signs and symptoms for referrals, sequestering of patients in HCs leading to dangerous delays, lack of appropriate transport to higher facilities, and poor use of counter references.

Health Worker Attitudes

USAID IHP supported mentoring during supervisory visits that included observation of clinical practices and counseling designed to improve health worker behavior. During CODESA meetings funded by USAID IHP, CODESA shared information elicited from community members on health worker behavior, which they reported to the IT, who subsequently met with the health worker in question. The program had trained health professionals at the DPS and BCZS levels on gender-sensitive approaches and supported the establishment of gender committees in the DPS and BCZS. A DPS representative emphasized that USAID IHP encouraged that at least 30 percent of CHWs be women. Neither HZ had received audits to assess gender-sensitive approaches at health facilities. The informant from Miti Murhesa mentioned that people struggled to understand concepts related to gender, adding that more awareness raising was needed, especially at the community level.

Innovative Financial Approaches

The World Bank started performance-based financing (PBF) in Sud Kivu about a year before the endline evaluation. The approach involved reduced consultation fees, which were posted at health facilities, and free care for vulnerable community members and malnourished children. Health mutuals were being introduced in the HZs where the endline evaluation took place, but uptake was limited. According to our informants, no financial approaches had been introduced by USAID IHP.

Objective 3: Increase the Adoption of Healthy Behaviors, including the Use of Health Services in Target Health Zones

Key informants stressed the important role that community activities played in increasing the use of health services. They described the configuration of the community health structures as comprised of village CACs, which included 7–20 elected RECOs who served as members of CODESA committees linked to HCs. Informants reported that the multisectoral CAC committees, which submitted monthly health activity reports to the HC, had become central to the community health activities. BCZS management teams and local NGOs contracted by USAID IHP worked with CHWs to ensure the implementation of activities designed to improve key household practices and health service use. Community activities that were mentioned as being carried out in Sud Kivu included awareness raising by RECOs, mini-campaigns, international days, and specific interventions, such as VIVA and community scorecards. However, DPS and BCZS key informants expressed concerns about the limited number of HAs in HZs that received financial support for the interventions. The USAID IHP key informant noted that some CODESA committees were not operational; those that were functional met monthly with support from USAID IHP and other IPs. Key informants indicated that in HAs supported by USAID IHP, the three-year mandate for CAC and CODESA committees recently ended, and revitalization was needed.

According to the USAID IHP informant, the program supported a pool of DPS trainers to train 15 RECOs in five HAs in target HZs. There was general agreement that training coverage of RECOs was insufficient, with many RECOs not having received any formal training. For example, zonal-level informants mentioned that in five targeted HAs, only one RECO received training on community-based contraceptive distribution and community scorecards. Informants also contended that trained RECOs often did not have an adequate understanding of the wide range of thematic areas that they were supposed to address during community activities. Although a DPS representative mentioned that BCZS supervisors mentored RECOs, findings from our midline evaluation and supervision study showed that mentoring was insufficient to address RECO needs.

Informants reported that mini-campaigns were implemented in USAID IHP-supported HZs to boost low-performing health indicators, with FP and TB mentioned as topic areas that had produced good results. Reported international days sponsored by USAID IHP included malaria, TB, vaccination, and women days. Key informants reported that community scorecards had been introduced in early 2024 in targeted HZs and HAs. Informants described community scorecards as an approach that encouraged HC and community members to work together to identify problems negatively affecting health services and to develop workplans entailing community strategies to remediate those problems.

Sud Kivu was one of the target provinces for implementation of the VIVA campaign, with key informants mentioning that when BA led the campaign, many DPS officials and BCZS representatives in the Walungu HZ received training on a range of thematic areas and support for implementation. At the time of the endline evaluation, USAID IHP was leading the scale-up of VIVA in eight or nine HZs, including both Walungu and Miti Murhesa, where VIVA had been introduced in all HAs, although only a few HAs were targeted in most HZs. Key informants mentioned that USAID IHP had provided limited training, some of which was done remotely, and that supervision of activities was limited. The DPS representative said:

> *We asked if it was possible for the partner to continue supporting the approach as before, because we are not assured that the approach is now well understood. We had*

to think what more needs to be done to achieve this objective of sustainability. But for the moment, I believe we risk losing everything. Although the approach is beneficial, we need to see how to redirect it and continue again.

When describing implementation, key informants indicated that CHWs, along with HC personnel, identified underperforming indicators and organized interventions to boost indicators. They mentioned that VIVA interventions continued to be reviewed during BCZS monthly monitoring meetings, and that the DPS carried out quarterly supervisory visits with USAID IHP support. Key informants raised concerns that the lack of motivation of RECOs, especially in HAs where RECOs had received financial support during the VIVA pilot campaign, was affecting interest in continuing the approach.

Key informants mentioned that USAID IHP community activities had improved service use related to CPN, CPS, child vaccination, and FP, explaining that monthly focal topics were guided by HA health indicators. They partly attributed improvements to the establishment of CACs, which they claimed showed signs of sustainability despite limited resources.

The following sections provide information collected in one higher performing and one lower performing HA, as well as at one reference hospital in the Walungu and Miti Murhesa HZs of Sud Kivu. Following the USAID IHP objectives, data are presented according to the following sub-sections: facility-based services, management and governance, resources for facility workers, and community health services. The information presented was derived from in-depth interviews, observations, and FGDs.

Sud Kivu Province: Walungu Health Zone

Facility-Based Services

Infrastructure

The Walungu HZ is in a USAID corridor where many other USAID-funded projects have been implemented. The HZ is comprised of 28 HAs, which have at least one HC, and five to six iCCM sites.

The higher-performing health area (HPHA), which is comprised of eight villages, has a HC located about seven kilometers from the reference hospital. Built in 2007, the HC had been renovated about six months before the endline evaluation. The building was too small to accommodate all activities, with the IT mentioning that the maternity ward did not meet national standards. As was the case in 2021, the laboratory was not functional, which the IT claimed affected service use, although the center did have a microscope provided by USAID IHP.

The LPHA, which is located 10 kilometers from the reference hospital, was also comprised of eight villages. Since the midline evaluation, a plot had been purchased for the construction of a new HC, and at the time of the endline evaluation, construction of the HC, which was financed by the World Bank *Agence d'Achat de Performance* (AAP, Performance Purchasing Agency), was underway. Informants reported that during construction, some of the HC equipment had been stolen, including a microscope recently delivered by USAID IHP. Although the HC possessed an older microscope, the LPHA laboratory was not functional.

The reference hospital was built in 1948, with the most recent renovations occurring in 2016 with financial assistance from the US government. Despite this, informants reported that many additional renovations were needed, such as repair of the cracked cement floor, which dated back to the Belgium era, and replacement of the toilets. Although the hospital had electricity, it was often insufficient to operate certain medical devices. Hospital administrators had approached IPs and the Congolese government for assistance with renovations,

but nobody had responded.

Services Offered

Health Centers

HCs offered similar services, including 24-hour treatment consultations for outpatients, overnight care for more severe cases, basic surgery, and MCH services, including CPN and postnatal consultation (*consultation postnatal*, CPON), delivery care, CPS, and FP. Informants explained that more severe patients could be treated at the HCs, and if there was no improvement after 72 hours or the condition worsened, patients were referred to the HGR. Both facilities had a maternity ward where traditional midwives assisted normal deliveries. Neither HC met the minimum package of health services and personnel, with both lacking a functional laboratory and lab technician. Diagnostic capabilities and curative care were basic.

ITs reported that nurses followed national protocol flowcharts for childhood illnesses during consultations, which provide treatment approaches for different pathologies according to the severity and characteristics of patients. ITs mentioned that they encouraged caregivers to return to the HC if the child's condition worsened and to avoid self-medication and use of traditional practices, such as visiting *chambres de prières* (prayer rooms) where children believed to be possessed by witchcraft were treated. The IT from the LPHA stated that they followed IMCI. Both ITs reported promoting preventive care during consultations, such as the importance of exclusive breastfeeding, complementary feeding, hygiene practices, vaccinations, and the use of insecticide-treated nets, according to the pathology presented and the child's condition.

Both HCs offered weekly CPS, which had been revitalized before the midline evaluation with USAID IHP support. Informants described CPS as more comprehensive than before revitalization, when the focus was on vaccinations, with sessions now including growth monitoring; administration of child vaccinations, vitamins A and C, and mebendazole; distribution of bed nets; and educational sessions on a variety of child health themes. Informants mentioned that the revitalized approach encouraged mothers to continue to attend CPS up to the time children reach five years of age. They also reported a greater focus on child nutrition, including active community screening for malnutrition, counselling on breastfeeding and complementary child feeding, culinary demonstrations, and the provision of supplementary foods (Plumpy'Nut) for severely and moderately malnourished children (although both HCs reported frequent stockouts of Plumpy'Nut). Informants said that there was a strong emphasis on ensuring that children were fully vaccinated. In this effort, community workers conducted visits to households where children attending CPS missed vaccinations to request that they return to the HC for vaccinations. The CODESA President from the LPHA claimed that mothers had become more interested in attending CPS, stating:

> *Mothers are no longer afraid of going to CPS like before, each mother wants to bring their child to the CPS. Before, mothers just left their children in the house or attended CPS just two or three times and then stopped. Now, mothers want their children to complete all the vaccinations, and you will see that children are in good health despite poverty.*

ITs also reported holding monthly CPS outreach visits in distant villages.

Focus group participants in both HAs expressed appreciation for the care offered at the HCs, highlighting delivery care, as well as CPN and CPS consultations. One informant in the LPHA said:

> *I often experience miscarriages, I did not know how many months my pregnancy was, I went to the center, they gave me medication and monitored me closely in the health center for a week. One night I felt the child move and I gave birth to a child weighing 3 kg. Those who saw me leave the household to travel to the facility were surprised to see me come back with a baby. Now no one can fool me into getting treatment elsewhere, we have a good health center.*

Several women in the HPHA stressed that they felt comfortable because health providers spoke to them in Mashi, the local dialect in the Walungu HZ. One participant from the HPHA said:

> *We were not giving birth at the hospital [HC] for fear of having to face nurses and midwives who we thought were incapable of speaking our mother tongue. We thought they mainly spoke French and a little Swahili, two languages that we do not master. The RECOs reassured us, and now there are many of us who give birth in our HC.*

Women participating in the focus groups appreciated the preventive messages shared during CPN and CPS consultations and postpartum visits, which they stated informed them on how to keep their children healthy, with participants reporting messages on exclusive breastfeeding; complementary child feeding involving nutrient-rich foods; measures to protect against malaria, such as the use of bed nets and ensuring proper sanitation around households; diarrhea prevention; and the importance of ensuring that young children were fully vaccinated. However, in the LPHA, some women complained about the reception they got at the maternity and the lack of nutrition supplements (Plumpy'Nut) available for treatment of malnourished children.

Reference Hospital

Reference hospital informants reported that they had a neonatology center that offered services for neonates with health problems immediately after birth, such as infections or asphyxia, or for premature babies; a malnutrition treatment center where they offered therapeutic milk and Plumpy'Nut; and pediatric care, including surgical care and physical therapy. Hospital clinicians followed official treatment protocols established by provincial and national authorities for pediatric emergency care, malnourished children, general pediatrics, and newborns, which delineated treatment according to different pathologies and ensured standardized, quality care. The medical doctor informant added that clinicians followed treatment protocols for leading childhood illnesses, including malaria, pneumonia, and diarrhea, according to the illness severity and age and weight of the patient, and emergency pediatric protocols for patients with TB, HIV, and malaria. The medical doctor reported that children were referred from HCs and posts, the reference HCs, as well as from "pirate" health facilities (unauthorized health structures managed by unqualified personnel).

Hospital informants reported that during consultations, health workers also counseled caregivers on preventive home care related to good hygiene, exclusive breastfeeding, child nutrition, and the importance of child vaccinations, with one medical doctor adding that USAID IHP had encouraged comprehensive care.

Equipment

Health Centers

About two weeks before the endline evaluation, both HCs had received extensive equipment and supplies from USAID IHP. Because the lower performing health center (LPHC) was under construction and there was limited space to store the recently delivered materials, the head nurse was unable to clarify exactly what the HC had received, although he did mention beds and mattresses, which the HC lacked during the midline

evaluation. Unfortunately, a microscope and glucometer delivered by USAID IHP had been stolen. The informant at the higher performing health center (HPHC) mentioned receiving beds, mattresses, a microscope, and a generator, as well as smaller supplies, such as dressing forceps, scissors, and medical clamps. Materials specific to childcare included a baby scale and an aspirator. When discussing the delivery of equipment, the HPHA CODESA President, who claimed that USAID IHP had been recently been absent in the HA, stated:

> *It was a whole batch of material that we received from USAID and that's when we confirmed that PROSANI still exists. We were no longer seeing PROSANI, we did not know if it is the DPS or BCZS which takes care of the work, but it has been a really long time since they made a presence in the HZ.*

Both HCs had solar panels, but the power generated was unstable and sometimes insufficient to light the HCs. Although neither HC had a functioning refrigerator at the time of the midline evaluation, in 2024, both HCs had a refrigerator. Only the HPHC had an incinerator that worked.

Both HCs had basic equipment, such as thermometers, stethoscopes, blood pressure monitors, and sterilization equipment, as well as a microscope. Neither HC had a consultation table for infants and children. HCs had a scale for newborns and infants, hanging balances with trousers, and height measures. Both HCs had educational materials, including flipcharts, as well as megaphones to share messages. It is important to note that many of the materials that the HCs needed during the midline had been provided, with the HPHC IT reporting that they were now well equipped to treat children. When asked about their current needs, both ITs mentioned laboratory equipment and a lab technician, and the LPHC IT also stated that the HC needed an electronic baby scale and an otoscope.

During the midline, the evaluation team learned that USAID IHP had trained HPHA health staff on the hygienic maintenance of latrines and had planned to construct improved latrines and showers, but hygiene and sanitation facilities had not changed since the midline evaluation, reflecting the discontinuation of USAID IHP WASH activities.

Regarding repairs, the IT from the HPHC mentioned that the new equipment was of high quality and working well, emphasizing the importance of maintenance. Both ITs reported that there was no set approach for repairs, adding that they used the HC revenue to repair equipment.

Reference Hospital

The hospital had essential equipment needed to treat adults and children, including adult, newborn, and children's scales; height measures; sterilization equipment; thermometers; stethoscopes; and timers. The medical doctor informant reported that the hospital had recently received extensive equipment from USAID IHP, mentioning beds, mattresses, microscopes, blood pressure monitors, an ultrasound machine, medical theater lamps, and devices for traction of broken bones, but adding that the list was far more extensive, and that the equipment had responded well to their needs. He raved about the ultrasound machine, which had been mentioned as an important need during the midline evaluation.

Informants mentioned that the hospital was still in need of several pieces of equipment, such as an electrophoresis device to provide care for children with sickle cell disease and a new X-ray machine. One informant also mentioned the need for supplies to treat malnourished children.

When in need of equipment, the hospital approached IPs or used revenue to purchase equipment. A hospital staff member oversaw repairs, and if he was unable to repair equipment, the hospital contacted technicians in the provincial capital, or sought assistance in Kinshasa. The administrator added that spare parts could be difficult to obtain.

Medication

Health Centers

ITs reported that they submitted a monthly drug requisition to the BCZS based on ongoing patterns of drug needs and the availability of medications in the zonal pharmacy, with both mentioning that they tried to avoid drug stockouts. Although drugs were supposed to be delivered every three months, ITs reported that the delivery of drugs was irregular and depended on the IPs in charge of delivering medications and the BCZS. The IT in the HPHC stated that drugs were generally delivered every six months and that they received far fewer drugs than requested. He stated:

We receive a few drugs in small quantities. Requisitions are never filled; you ask for 10 boxes and only get two… Before three months, the medicine will be out of stock. And we will go six months without getting another supply.

The CODESA representative, who is supposed to oversee HC drug stocks, from the same HC said:

> *We withdraw much more money than what we received in medicines, last time I saw 575 USD withdrawn by the health center for the purchase of medicines but when I saw what they sent here it was too little, it couldn't even last a month, and I felt that this was theft…. Not all the drugs were there, according to the request…. If you go to the place where they sell the drugs, you can get a lot of medications for over 500 USD, even for up to three months, but we only received a small box of drugs. There was a serious inconsistency between the amount delivered and the drugs purchased, and I had difficulty even signing for this delivery.*

By contrast, the IT from the LPHC indicated that the drugs received generally met their requests, except for certain drugs that were frequently short in supply. He added that stockouts generally did not last for more than a month, which was an improvement compared with the midline evaluation, when the IT from the same HC complained that stockouts in the past several months were due to late drug deliveries from USAID IHP.

Both ITs mentioned that medicines supplied by USAID IHP reduced the number of medications that they previously had to purchase from pharmacies to maintain drug supplies. The LPHC IT said:

> *There have been positive changes. Today there are fewer drug shortages, the quantities that arrive generally comply with our requisitions, I would say the change is really positive. The health center always has medicines.*

ITs also recognized that the drugs provided by USAID IHP were of high quality.

At the time of the evaluation, both HCs had essential drugs for treatment of childhood illnesses, such as zinc, ORS, amoxicillin, ACT and other malaria medications, vitamin A and mebendazole, although antibiotics were limited. Both ITs reported frequent stockouts of antibiotics, and the IT from the HPHA also noted regular stockouts of malaria medications, which he mentioned were often not delivered. When stockouts occurred, nurses generally gave patients drug prescriptions until they could restock the drug through the BCZS, and if it was not available, they travelled to Bukavu where they could purchase drugs. As reported during the midline,

HCs had an incentive to buy less expensive, unregulated drugs. However, some special imported drugs, such as ACT, were difficult to replace. The CODESA President, along with other community health actors, were responsible for keeping the population informed about drug shortages and when medications were restocked and available in the HC.

Reference Hospital

Due to the infrequency and small quantities of drugs delivered, informants mentioned that the hospital had to replenish drugs monthly from drug vendors in the provincial capital of Bukavu. At the time of our study, the hospital had stocks of essential drugs for treatment of childhood illnesses, such as zinc, ORS, amoxicillin, ACT and other malaria medications, vitamin A and mebendazole. Informants reported that they monitored consumption of essential drugs, and when stocks were low, ordered supplies from a provider in Bukavu to hold them over until drug requisitions submitted to the BCZS were filled. Hospital informants agreed that they rarely had stockouts of essential medications, but when this happened, a generic substitute might be available in the hospital pharmacy. When more specialized medicines were out of stock, such as drugs for cough or antifungals, patients were given a prescription to purchase the drug at a pharmacy, although the medical doctor added that the population was poor and often these medications were unaffordable or difficult to access. Stockouts of supplies for the treatment of malnourished children, such as specialized milk products, were more difficult to obtain, and hospitalized children who were in need of immediate care had to be sent to another facility offering therapy for malnourished children.

Use of Services

Health Centers

ITs and CHWs cited poverty as the primary obstacle to care seeking at HCs. Some mentioned that despite reduced fees introduced with the AAP project, many people could not afford healthcare or that concerns about the cost of care encouraged care seeking elsewhere. Informants reported that many people first opted to purchase medicines at "pirate" HCs, obtain indigenous medicines, seek care with traditional healers, or take the patient to a prayer room[3] where religious leaders prayed for the patient, all of which could cause significant delays in care seeking from formal health facilities. A RECO from the LPHA said:

> *Another obstacle relates to traditional beliefs. If a person falls ill, they may not think that doctors can treat the illness, but the person will think it is supernatural forces and prefer to go to prayer rooms or to somebody who worships fetishes or marabouts. For example, one day, my child fell ill, and I wanted to take the child to the health center, but my grandmother forcefully took the child, telling me that in the health center they will inject him with medicine, and he will die. My grandmother took the child for prayer, claiming that the child is making gestures and therefore possessed by demons… In our village many churches espouse similar beliefs. For them, all illnesses are caused by witchcraft, there are also witch doctors who tell people that somebody bewitched him.*

The same barriers related to traditional beliefs were reported during the midline evaluation, highlighting their prevalence and their influence on healthcare use.

[3] It should be noted that some informants underscored efforts by territorial officials and local leaders who were developing approaches to reduce the use of prayer rooms.

The IT from the HPHA also considered the poor reception of patients by health facility workers, and the fact that the HC did not have a functioning laboratory, as factors that negatively affected the use of health facility services. Poor roads, especially during the rainy season when roads become impassable, was a major obstacle cited by the IT from the LPHA.

Focus group participants from the HPHC claimed that they only used other facilities when they were referred by the health workers, underlining that health workers provided good treatment, allowing patients to recover from illnesses. In their view, the primary obstacle to care seeking related to costs, with women reporting that HC workers treated on credit but only for a few days, and that they stopped treatment if payments were not made. There was also mention of drug stockouts, especially for malaria treatment, and the fact that the HC lacked a laboratory to diagnosis illness conditions. In the LPHA, women also cited positive aspects of HC care, including that patients were well received by health workers, treatment was provided on credit, and providers referred severe cases to higher-level facilities. However, women also mentioned that the HC experienced shortages of critical medicines, such as amoxicillin, and lacked laboratory equipment to diagnosis illnesses, which was offered in nearby facilities. Others reported that obstacles to facility use included poverty, distance, and lack of space for patients to maintain privacy, especially in the maternity ward. One woman described a recent delivery experience as follows:

> *I looked over and saw this 10-year-old child. Unable to do anything, I turned around, alone on my bed with my contractions, thinking that if there was a real maternity ward here, I would be with other pregnant women, and this child would never know the condition I was in. I don't know what this child told his parents or other villagers. Lack of space is really a big problem.*

Participants in the LPHA focus group minimized the use of self-medication, traditional remedies, and prayer rooms, and denied the existence of religious prohibitions that could interfere with biomedical care, whereas women in the HPHA reported the use of locally purchased medication and acknowledged obtaining care from traditional healers. Unfortunately, RECOs participated in both focus groups, which likely influenced participant responses.

Reference Hospital

One doctor from the reference hospital cited poverty as the biggest obstacle to care seeking from the hospital, which he stated influenced the use of home treatment, traditional healers, prayer rooms, and "pirate" HCs, and caused dangerous delays, sometimes leading to death. He said:

> *There are times when caregivers use traditional medicines to treat their children, causing the child to encounter complications or even die. There is a lot of that in the village, and lots of children do not reach the hospital… Prayer rooms are a big problem, they sequester sick people without knowing what they are suffering from; they say that they will treat them, without diagnosing the problem. They ignore the sickness but say they will pray for them…When children are brought to us, they are often at an advanced, complicated stage because they have already gone to prayer rooms, to traditional practitioners, who take pathologies as mystical things. When they come to us, they have already received lots of medicine, suffer from complications, and are intoxicated.*

The same informant stressed that, although USAID IHP interventions targeted pregnant women or mothers of young children, children were often cared for by other family members. He said:

> *We have this problem, in our environment most of the children are abandoned by their parents. The majority, 75 percent, are looked after by their grandmother, the children are often cared for by their aunts, their big sisters, or big brothers. We have a big problem, because counselling is mainly given to the mother after birth….*

The same informant considered the HC workers as another obstacle to hospital care, stating that the IT confined patients in the HC before referring them for advanced care. He reported:

> *All of this is linked to poverty. The IT incarcerates him [the patient], that's another challenge, another challenge. It's this poverty that causes gangrene, isn't it? The patient always comes late, late, after having tried here and there... Yes, the IT holds him back [in the health center], because if he [the IT] does not have sick people, how can he survive?*

The doctor also considered distance and transport costs, as well as the fact that patients might not have family members to care for them, as major barriers to acceptance of hospital referrals. He added that although hospital consultations had been reduced, people had tremendous difficulties paying 45 USD overnight fees.

Management and Governance

Coordination

Health Centers

Informants reported that they continued to hold monthly HA reviews with the IT, CODESA members, and RECOs to compile data and evaluate HA activities. ITs mentioned regular participation in the BCZS monthly monitoring meetings attended by the zonal health team, all HA ITs, and sometimes IPs, donors, or DPS officials during which each IT presented monthly health indicator data. Informants stressed that this forum continued to present an important opportunity to share field experiences. The IT from the LPHA said:

> *In meetings we talk about everything, they are informative with the active participation of all attendees. Challenges are shared and possible solutions are identified. Indicators that are decreasing get particular attention and possible solutions are identified in the meetings.*

The same IT mentioned that monthly meetings presented one of the few opportunities to interact with higher-level government officials, IPs, and donors about their work; however, there was no mention of USAID IHP's involvement in review meetings. One CODESA President reported that USAID IHP had become less visible during review meetings, supervisory visits, and in the zone, in general. Training sessions also provided opportunities to interact with higher-level government officials and IPs, share field experiences, and learn from other colleagues. One IT mentioned that USAID IHP had encouraged them to increase exchanges about work experiences with their colleagues.

Both ITs mentioned that they participated in local meetings designed to improve the role of community health actors and community development.

CODESA member informants reported participating in committee meetings to develop action plans and share experiences, as well as attending HA monthly review meetings and occasional meetings in the BCZS when a problem affecting the entire HZ arose. At the village level, CODESA Presidents met with CAC members and RECOs to talk about community health needs and development strategies. CODESA Presidents and RECO

informants mentioned that training sessions also offered opportunities to share experiences and work challenges with other ITs, IPs, and higher-level officials, with one CODESA mentioning that the VIVA campaign facilitated interactions with government officials. During supervisory visits, community agents might meet with DPS and IP representatives, although these opportunities were reported to be rare. There was agreement that community agents' participation in meetings and training had recently become less frequent, which likely reflected changes in the USAID IHP approach, with the CODESA President from the HPHA reporting that for more than one year, CODESA members had been excluded from participating in monthly zonal reviews.

Reference Hospital

The medical director and nursing director were both members of the zonal management team, which met once a week to review the status of zonal activities and participated in BCZS monthly reviews and supervisory visits of HCs. According to them, meeting forums and supervisory visits provided opportunities to exchange experiences, share best practices and challenges, improve collaboration, and make recommendations for improvements in health worker performance. Members of the hospital staff also participated in DPS integrated supervisory visits but rarely attended meetings with DPS personnel. After participation in training, hospital staff held debriefing sessions to share new information learned during the training with other clinicians. These sessions were also perceived as an opportunity to improve dialogue and collaboration among hospital workers.

Accountability Mechanisms

Informants mentioned several mechanisms to report problems related to HC activities, including the greenline, community scorecards , and through individual reporting to the CODESA President, IT, or health officials in the BCZS. Both HCs had removed the suggestion boxes introduced by other IPs that the evaluation team had observed during the midline evaluation.

All informants were aware of the greenline, which had been introduced since the midline evaluation, mentioning that the 45005 number was posted in each HC and in the hospital. Although most informants stated that the line was available to report problems at the health facilities, such as corruption or abuse of materials, a couple of informants believed that it was to report sexual abuse carried out by health workers. In the HPHA, three phone lines had been installed by different IPs, all with varying objectives, causing confusion. The IT in the LPHA believed that a different IP had installed the USAID IHP fraud and abuse accountability hotline. ITs reported that the greenline had never been used, with both speculating that people were fearful that there might be repercussions for denouncing bad behavior. In the hospital, the hotline had been used, and in one instance, a call generated an investigation by the IPS.

With support from USAID IHP, the HPHA had initiated community scorecard activities, which the CHW informants stated allowed community members to monitor health structure activities, including IT performance. Community agents had been trained on the approach, and a plan had been developed, although the CODESA President suggested that they needed more financial support from USAID IHP. The RECO said:

> *Bulletin communautaire de performance [BCP; community scorecard] is very important because the nurse is a person, he may think that these are his medicines, but the community comes and tells him that the medicines belong to us too and need to be used for our treatment. It is the community that ensures that the medicine be kept at the health center, and the community can say what they want, and the nurse must respect*

that. The work will go well because there is an understanding between the community and the health center.

Informants reported that community members continued to share grievances (e.g., poor reception by health workers, refusal to treat patients lacking money, receipt of prescriptions rather than drugs) with the CODESA Presidents, which were subsequently introduced to the IT or the MCZ. They considered this as a preferred approach because it facilitated discussions and often led to positive changes. The IT from the HPHA submitted narrative reports to the MCZ when a health worker behaved inappropriately, indicating that he counseled the health worker regarding ways to improve.

Several informants acknowledged that USAID IHP had played a key role in setting up accountability systems to encourage information sharing between community members and health workers, decrease negative practices at the facilities, and encourage health workers to comport themselves well. The IT from the LPHA acknowledged that these efforts, combined with other USAID IHP-supported activities, such as the provision of medicine, equipment, and training, worked to increase service use. He stated:

These approaches aim to change the behavior of health providers. For example, when medicines are available in the center, utilization increases and generates revenue, a percentage of which goes to health worker payments. Villagers are encouraged to use the services. When the equipment is there, we can also hope that attendance will improve. Even the RECOs receive something during training. All this pushes providers to behave well in front of community members. It is the community which is our boss, we accept how they act and what they can pay.

Health Financing

Health Centers

The introduction of AAP, which occurred about a year before the endline evaluation, led to many changes in healthcare financing in the Walungu HZ. Consultation fees for children and adults and observation costs had been reduced, with fees posted in both facilities. When talking about the reduced fees, the IT in the LPHA said:

The result is positive, in a poor environment like ours, such a reduction in health costs contributes to easier access to health, and therefore to good health at lower costs.

In each HA, 50 vulnerable community members were identified as eligible for free healthcare at the HCs and subsidized care at the HGR. AAP also paid for ambulance transport of vulnerable patients. The approach provided quarterly performance-based subsidies for operational and health worker costs, including payment to community health agents who were supposed to receive 5 percent of the increased revenue. However, at the time of the endline, informants in the HPHA mentioned that subsidy payments were more than six months late. Although informants from both HAs agreed that reductions in healthcare costs and subsidization of treatment for the poor had eased access to care, they emphasized that some members still could not afford care. As a result, health workers at both HCs continued to treat on credit and debt was incurred by many community members.

Informants were unaware of other initiatives, such as bonds or emergency funds, although there was mention of a health mutual operating in the LPHC.

Reference Hospital

With the introduction of AAP, hospital consultation fees had also been reduced, although hospital staff

admitted that the reduced fees were still unaffordable to many. The hospital maintained lists of vulnerable community members from the 23 HAs eligible for free care, and the AAP also financed care for other hospital patients considered indigent. Informants reported that sick patients requiring immediate care were admitted to the hospital notwithstanding their financial situation, but payment had to be made at discharge. Hospital informants stated that reduced fees and free care for indigent patients had increased the demand for care.

The hospital continued to accept different financing mechanisms, such as health mutuals and bonds provided to employees of organizations or companies that signed a contract with the hospital, but that they were rare.

Both HC and hospital informants were unable to identify specific ways that USAID IHP had contributed to health financing, although clinicians noted that that the provision of reduced medications and equipment increased health service demand and revenue. The medical doctor also mentioned that training offered by USAID IHP had improved quality of care and increased healthcare use.

Resources for Facility Workers

Staff in the HPHC included two A1 and three A2 nurses,[4] including a midwife, an A3 worker who assisted deliveries, as well as a receptionist. The LPHC had four A1 workers, including a trained midwife, and three A2 workers, including a nutritionist and an assistant/cashier. Neither HC met government standards regarding health worker staff.

Training

Health Centers

Informants mentioned many training sessions that health staff had participated in since the midline evaluation, but most were not sponsored by USAID IHP. This was in sharp contrast to information collected during the midline evaluation, which suggested that USAID IHP sponsored many training programs, and reflected the change in the USAID IHP approach.

Several community health agents mentioned participating in training believed to be led by USAID IHP, such as awareness raising on the need for child vaccinations, child nutrition and management of malnourished children, and the operation of CACs, although the timing was not always clear. Some also reported participating in VIVA training in the past year. The CODESA President in the LPHA mentioned that many new RECOs had never received an orientation, and as a result, had not mastered the work and were unable to lead awareness raising sessions, such as during CPS and CPN. He added that when training occurred, only two to three of the 50 active RECOs participated, limiting their effect.

Reference Hospital

Similarly, hospital informants reported that very few training sessions had taken place since the midline, with the informants only mentioning that hospital staff had participated in recent training on how to treat malnourished children and use diagnostic imagery. The medical doctor informant, who was an expert in neonatology, expressed many reservations about the USAID IHP approach to training, stating that the entire focus had been on maternal health, with no training on child healthcare and treatment. He had only

[4] A1 nurses hold a higher diploma in nursing, typically obtained after completing three years of post-secondary education. This level is equivalent to a bachelor's degree in nursing. A2 nurses usually have completed secondary-level education and a subsequent two-year diploma or certificate in nursing. A3 nurses generally have a lower level of nursing education, often completing a one- to two-year training program after secondary school, or sometimes just a vocational-level training.

participated in one USAID IHP training in 2021, which was on obstetric care. The same doctor questioned the selection of participants in USAID IHP training, stating:

> *For example, for the management of childhood illnesses, instead of training workers in the pediatric or maternity services, you come and train the BCZS staff, you train the nursing supervisor, and the training can go unnoticed in the hospital. Me, for example, who is a member of the pediatric team, is left out and you train the RECOs.*

Although both informants highlighted that USAID IHP offered high-quality training, the medical doctor emphasized that USAID IHP should target all services, rather than only focusing on maternal health, and that more training was needed.

Supervision

Health Centers

Head nurses reported receiving supervisory visits by the BCZS at least monthly when supervisors identify problems and make recommendations regarding how to address challenges, with ITs mentioning that supervision often focused on childhood vaccinations and maternal health. During subsequent visits, supervisors assessed whether health workers had adhered to the recommendations. Both ITs considered the support provided during supervisory visits as critical to the improvement of health services. Head nurses also reported receiving visits from DPS officials every semester to assess the evolution of health services. The HPHC IT described a recent visit by USAID IHP staff involving monitoring of the equipment received.

Reference Hospital

Hospital workers mentioned receiving supervisory visits from IPs supporting treatment of malnourished children to assess whether materials were available for treatment. They also mentioned monthly supervision visits by the BCZS management team, two of whom were hospital personnel, and occasional integrated supervisory visits by DPS personnel. One hospital informant described a recent visit by USAID IHP staff to assess the status of the medical equipment recently provided to the hospital.

Access to Continuing Education

Health Centers

Informants reported that their main source of information was through training and during meetings and formative supervision. Although they expressed gratitude for these opportunities, informants indicated a need for increased access to information so that they could improve their work performance. No informants mentioned receiving new written materials, and our observations found limited documentation available at HCs.

Reference Hospital

Both hospital informants reported that they obtained medical information through the Internet and training. The medical doctor emphasized the need to receive regular, updated information to keep up with the constantly changing field of neonatology and child health, and to improve quality of care.

Attitudes of Health Workers

Health Centers

There was general agreement that health worker behavior was critical to the use of health services, especially in village settings where negative interactions could circulate quickly, damage the HC reputation, and rapidly affect healthcare use. The midline evaluation results highlighted several instances of negative health worker

behavior, which were also reported during the endline evaluation. Just before the endline evaluation, the HPHC had received complaints from community members about negative health staff behavior. Both head nurses emphasized the importance of treating patients with respect, noting the need for improvements. The IT of the LPHC said:

> *Yes, there is bad behavior exhibited by health providers, especially when welcoming patients. A patient who is poorly greeted at the reception may get the impression that they are being ridiculed or the nurse does not care about them. Bad reception is the most common negative behavior that I can report here at our center…. In the village everybody finds out about things, and that can damage the reputation of the HC.*

Both HC ITs shared other examples of negative exchanges between health workers and patients that often involved payment for care, noting that these instances were inevitable in their environments where health workers were poorly compensated. The HPHA CODESA President said:

Mistakes occur like the health worker neglects the patient, or when a patient talks to a service provider, the worker looks at him like he is not a person, neglects the patient, or looks at the patient with suspicion. This creates a climate of distrust instead of collaboration with the client.

When these instances occurred, community members generally complained to the head nurse or shared their grievances with the CODESA President, and the IT subsequently counseled the health worker involved. Several informants mentioned that regular one-on-one counseling with health staff was essential to maintaining positive attitudes and behaviors, as was regular dialogue with community representatives. Neither IT had participated in training on health worker behavior, nor had they received assistance from USAID IHP or other IPs to address these issues, with both adding that training would be useful.

Reference Hospital

Hospital workers could not recall an instance when health workers behaved inappropriately toward patients or parents of children, underlining that inappropriate behavior could affect health seeking and that the hospital management would not tolerate this. The medical doctor informant said:

> *It is not common because our focus is on welcoming the sick and providing good care. And if there is a blunder, I don't see management crossing its arms and remaining silent. Such a blunder can affect work, because a patient who is not well cared for, who is not well-received, tomorrow, he will not come back. It will impact the hospital attendance.*

Informants reported the need for improved remuneration and training to improve health worker behavior, with both noting little emphasis on health worker behavior during training.

Health Worker Sources of Motivation

Health Centers

HC workers continued to rely primarily on monthly revenue for compensation, which was distributed among staff according to educational levels and performance in the health structure. Informants reported that some health staff received the government bonus, which they described as infrequent and minimal when it was distributed. Although the World Bank PBF initiative, which was designed to increase health worker compensation, had been recently introduced in the Walungu HZ, informants reported that payment was often late, and drug requisitions were frequently not filled as requested. Despite this, informants agreed that the approach motivated them to improve their performance. When talking about compensation, the IT from the

LPHA said:

> *We chose this profession out of interest and love for the population. But a hungry belly has no ears. You find an IT with a government registration number but without salary. In an HC of 11 people, seven receive a risk bonus and they receive a small performance bonus drawn from the center's low revenues in an environment where the population is poor. The health center revenues are kept low because the center receives a subsidy from AAP, which reduces treatment fees. We also receive medicines from USAID IHP to increase the demand for services.*

The same head nurse reported receiving 333,000 Congolese Franc (CF) (118.93 USD) over three months, or about 2750 CF (1 USD) per day, adding that he was the best paid worker in the health structure. He also noted that in the month of February that year, the HC had generated 13,000 CF (4.64 USD) in revenue, once again underlining the challenges of working in a poor environment.

Health workers faced difficulties responding to questions on how USAID IHP support affected their motivation or satisfaction, which they generally linked to monetary compensation. When probed about the effect of USAID IHP-sponsored training and the receipt of medications and equipment, they acknowledged that training could increase the quality of care, and in turn, increase demand for services, although both ITs added that the use of services remained low. The IT from the LPHA noted that not all health workers participated in USAID IHP training, and although debriefings were held post training, the approach diffused the quality of learning. He added that the equipment and drugs received from USAID IHP had been beneficial, but neither IT felt that USAID IHP support increased remuneration.

Reference Hospital

As was the case during the midline, none of the hospital staff received government salary. Rather, they relied on hospital revenue and occasional risk bonuses, which were described as miniscule. The medical doctor emphasized that the hospital, which is self-financed, operated in a poor environment that limited the use of hospital services, adding that the hospital had to compete with traditional healers, prayer rooms, and “fake” structures to generate revenue. The medical doctor referred to hospital remuneration as “catastrophic,” explaining that that doctors earned 20 or 30 USD a month. Given the low salaries and morale, he stated that it was difficult to consider other forms of motivation.

When asked about the contribution of USAID IHP to motivation, the medical doctor indicated that USAID IHP had not provided funds to assist hospital operations and salaries. Although he acknowledged that training boosted work satisfaction and patient care, he suggested that staff would only feel the impact of the program if direct funds were provided to the hospital.

Community Health Services

Infrastructure

Health Areas

Informants described the community health structure as comprised of CAC committees, CODESA committees, RECOs, and community leaders. The HZ established CACs in each HA village in 2020 when communities elected board members and trained CAC members, CODESA members, and RECOs on the organization and role of the CAC. CHWs described CACs—each of which included at least seven RECOs—as an essential component of the community health structure due to their proximity to village residents and linkages with CODESA committee members and facility health workers. CAC members were responsible for informing the

population about health issues and encouraging community members to frequent HCs. Community scorecards had been introduced in the HPHA, although the IT did not know how they worked.

Routine community activities involved awareness raising about upcoming events or health concerns, and household visits during which CHWs disseminated information on illness prevention, especially related to children, and identified and referred sick patients to facilities. In both HAs, informants mentioned that CODESA members and RECOs worked with churches, local associations, and schools to propagate health information. Other community activities included community outreach in distant villages involving anthropometry assessments, vaccinations, and educational sessions.

Informants reported that HC staff members occasionally participated in community meetings or carried out household visits with RECOs to speak to community members reticent to participate in HC services, such as CPN or CPS, or assess severely ill patients requiring special medical care. Community health actors mentioned that the presence of facility workers in communities raised the credibility of the messages that they shared.

During the midline, hospital staff mentioned occasionally participating in community radio emissions that conveyed information on childhood illnesses and health, but that they had been discontinued due to lack of funding. There was also mention of the recent introduction of health messaging on Walungu community radio, which might have been part of the VIVA mass media campaign.

Informants reported occasional campaigns involving vaccinations, vitamin A, deworming medication, and bed net distribution when community actors were responsible for informing the public about the campaign or were involved in actual distribution, with informants from the HPHA reporting recent involvement in a OPV campaign. Most informants described mini-campaigns as events when community health actors carried out house-to-house visits to identify children who had not been vaccinated or had missed a vaccination, with some mentioning that USAID IHP supported this activity. Fewer informants described occasional community screening for malnourished children as constituting a mini-campaign. Community health actors had been trained in champion communities before 2019, but no champion community interventions were active.

Both HAs had nutrition support groups led by RECOs targeting pregnant women and young children, although some informants stated that USAID IHP did not sponsor these activities. Informants reported monthly meetings when nutrition education sessions promoting improved dietary practices were held and culinary demonstrations involving preparation of enriched complementary foods might be conducted. One RECO mentioned that these sessions had little impact because people did not have money to follow the nutrition counseling.

In the HPHA, the IT mentioned that community workers were involved in identifying and referring TB patients to TB centers, and monitoring drug regimen compliance.

Informants mentioned that flip charts were kept at the HCs and used to lead educational sessions during CPS, CPN, and community meetings. Most informants indicated that the messages conveyed were appropriate and easy for community members to understand. The LPHA CODESA President mentioned that awareness raising skills varied across the RECOs, adding that some RECOs had not been trained and were incapable of conveying messages properly. Except for some materials introduced by VIVA, it appeared that educational materials had not changed since the midline evaluation, and that the same messages continued to be repeated. Community health actors reported that that the flipcharts were insufficient for the work of all RECOs working across the HAs. Because they were stored at the HCs, the evaluation team concluded that education materials were

mostly used during CPN and CPS sessions.

Unfortunately, the evaluation team was unable to assess the regularity of the community health activities, which would require more time in the field. However, several informants reported decreased motivation by community health actors, except during campaigns that offered incentives. Some raised concerns about the sustainability of community health activities, noting that requests for compensation and the refusal to work for free had escalated. Several informants ascribed this change to the introduction of incentives during the VIVA campaign, which had subsequently been removed. Informants mentioned that training involving CHWs had significantly decreased or stopped since the midline evaluation, also affecting community health actors' motivation and interest in their work.

System Design

Role of CODESA Members

Informants' descriptions of the role of CODESA committee members were similar to data collected during the midline. They indicated that CODESA members served as a link between the health structure and villages to ensure that information between community members and health personnel was exchanged. Informants described two CODESA committees: a larger CODESA committee comprised of all RECOs representing the CACs and the central CODESA committee, entailing its elected members who oversaw CAC committee activities. CAC presidents elect the CODESA president and other committee board members.

Informants indicated that CODESA members oversaw the use of HC supplies and medications, assisted with the organization of CPN, CPS, and outreach visits, carried out household visits and oriented sick patients to the HC, raised awareness about the use of HC services, helped identify indigent villagers, and oversaw the work of the RECOs. They also collected monthly CAC reports related to village health activities led by the RECOs in the HA villages, compiled the data, submitted the reports to the IT, and participated in the HC monthly review. During monthly CODESA meetings, participants assessed monthly CAC reports and identified positive and negative aspects of community health activities, which informed the focus of community agent awareness raising, also taking into consideration data reviewed during the HA monthly meeting. The IT from the LPHA said:

> *In our health area, we have eight CACs, they have a meeting once a month, they get together. They discuss and observe what went well, they look at what is wrong, they look at how they can overcome the challenges. And when things aren't going well, they call me, they tell us what isn't going anywhere…They have a meeting once a month. We also have a meeting, an extended meeting [involving community agents]. We invite all the CAC committees, and the CODESA committee. Here we identify the negative and the positive points [related to monthly activities]. Regarding the negative points, we propose possible solutions. They help us meet these challenges, especially when there is low use of services. We ask them to help us increase awareness so that services are used, and they execute.*

The evaluation team noted improvements in the organization of the CODESA committee. The change likely reflected the revitalization of the CAC and CODESA committees, which with support from USAID IHP, had occurred just before the midline evaluation, and the active participation of CAC RECOs in the CODESA committee meetings. CAC monthly activity reports appeared to be routinely gathered and submitted to the CODESA President in charge of compiling the information, which was shared during the monthly HC

monitoring meetings. Changes in the CODESA committees may also have been related to interventions led by VIVA in the Walungu HZ. However, some informants mentioned that since the withdrawal of BA, some CACs had decreased their activities or members had left. The RECO informant from the HPHA said:

> *There are community relays who are becoming lazy……. When VIVA started with CACs, the community relays were very active because there was motivation, but when there was no motivation, some RECOs reduce their pace. No one monitored the activities or requested reports. They realized that there was no longer a motivation, and if there is no motivation, not all workers will be active, but if there is motivation everyone will be active.*

Informants mentioned that VIVA offered many training sessions for CODESA members, and that VIVA had provided 100 USD for the functioning of the CODESA committee. There was no mention of the money (30 USD) currently provided to the CODESA committee by USAID IHP.

As to the composition of the committees, the HPHA had five members, including two women who served as treasurer and advisor, whereas the LPHA committee included eight people, including four women, one of whom was the committee vice-president. Some informants noted an increase in the number of women on the committees.

It is important to note that both ITs were unaware of the number of members on the CODESA committees and aspects of their work, highlighting the need to improve collaboration between head nurses and the CODESA members. Several informants noted that USAID IHP, which had been involved in the CAC and CODESA member revitalization efforts, had not been active in community activities for about two years.

Role of RECOs

RECOs, who were elected as CAC members in their respective villages, were responsible for maintaining routine data on community health activities and household visits (including the numbers and topics covered), which were submitted to the HC at the end of each month. Their involvement in the CAC committees, along with an increased focus on monitoring village health activities—which occurred around the time of the midline evaluation with the revitalization of the CACs—appeared to add purpose, accountability, and structure to their role. Several informants mentioned that the reporting of community activities had become more regular, which some attributed to efforts by USAID IHP.

Daily RECO activities appeared to remain the same as described during the midline evaluation, although informants mentioned that RECOs followed about 15 households, which was fewer than reports given during the midline evaluation. Routine activities involved household visits to monitor the health of community members, especially children; the identification and referral of sick members to the HC, including malnourished children; and raising awareness about essential family health practices. RECOs were also responsible for informing villagers about health events, such as CPN and CPS sessions and campaigns, and assisting health personnel during CPN and CPS sessions and outreach visits. RECOs were also tasked with seeking out mothers and children who did not attend the CPN and CPS sessions, children who missed vaccinations, and promoting the use of facility services.

In 2020 and before the midline evaluation, RECOs had been elected for a three-year term in each HA community. After elections, selected RECOs participated in training designed to orient them on their role and the operations of CACs, all of which was supported by USAID IHP; however, CHW informants complained that

the training included a limited number of participants. Since the midline evaluation, RECOs had participated in training led by other IPs, particularly VIVA, but not by USAID IHP, once again mentioning that training typically targeted only two or three RECOs. Several informants mentioned that many RECOs, especially younger members, had not received a formal orientation and were unequipped to work effectively. Several informants noted a sharp reduction in activities since the departure of VIVA.

Informants from the same HA reported different numbers of active RECOs, reflecting the regular attrition of members. In the HPHA, informants reported 37–45 active RECOs, whereas in the LPHA, informants stated that 50–68 were active. In both HAs, informants mentioned that the majority of active RECOs were women, and that youth were also participating. Informants suggested that election criteria for the CACs encouraged participation of both youth and women, with some noting that women were now elected for leadership roles on CAC and CODESA committees. Reports of negative behavior manifested by community health agents were rare, with informants explaining that community health actors were selected by villages based on their behavior. ITs recommended that RECOs needed more training and other forms of motivation to increase community efforts.

Focus group participants reported that RECOs actively shared messages by megaphone, and during household visits, encouraged the use of HC services, such as vaccination administration, and promoted preventive measures, such as the importance of using bed nets, maintaining sanitary compounds and good hygiene, exclusive breastfeeding, consumption of nutritious foods, birth spacing, attending CPN consultations early in pregnancy, vaccinations, as well as seeking rapid treatment at HCs for childhood illnesses. RECOs were also reported to make announcements when medications or vaccines arrived at the HC. Women from both groups reported high acceptability of most messages, with a woman from the LPHA stating:

> *The RECOS reduced our fears of going to the health center, by reassuring us and calmly explaining to us in Mashi [the local language], about the services offered at the health center.*

Women from the HPHA added that RECOs went door to door identifying sick patients and served as an important liaison between the HC and the community.

Participants were generally enthusiastic about the role that RECOs played to keep community members informed about health issues, facility services, and events, such as mass campaigns, with participants citing campaigns involving vaccinations, bed nets, recovery of children who missed vaccinations, and vitamin A and mebendazole distribution. Women also confirmed that RECOs insisted on the use of health services. Some mentioned that not all mothers adhered to health practices recommended by the RECOs, with one participant in the LPHA group stating:

> *Some women have the intelligence of a cow, it is not the fault of the RECOs, because they are doing their awareness-raising work properly.*

Interestingly, women in the LPHA focus group stated that RECOs sometimes threatened to call the police if women did not attend services designed to improve the health of young children, such as CPS and vaccinations.

FP was the one topic reported by women to be controversial, with women from the LPHA explaining that religious leaders advocated for women to produce more children, whereas health workers taught women how

to limit childbirth, with some women claiming that the health workers messages were often not convincing. Women from the HPHA reported that negative side effects, such as excessive bleeding, continued to impact the use of contraceptives, and that only God could determine when children were conceived. Participants reported limited male involvement on issues related to reproductive health.

Other sources of health information mentioned by focus group participants included churches, schools, the radio, and telephones, although people from the LPHA added that few women owned phones. One participant in the HPHA mentioned receiving information on the market during a market quiz.

Specific Services Offered

Bed Nets

Informants reported that bed nets were distributed to pregnant women during the first CPN visit and to mothers during CPS when children were fully vaccinated. Informants assumed that USAID IHP, which some mentioned provided assistance to CPN, CPS, and community weighing, supported the distribution of bed nets during HC services. Informants mentioned occasional stockouts of bed nets but added that women were summoned to the HC when bed nets became available. RECOs were responsible for monitoring how bed nets were set up and used during household visits.

Mass distribution of nets to the public had been conducted for about two years before the endline evaluation, but informants reported that they were unable to accommodate all community members with a bed net. In addition, informants reported that bed nets were often poorly installed and maintained, and did not last long, or they were used for other purposes. As a result, informants suggested that many community members did not sleep under bed nets.

Focus group participants mentioned receiving bed nets during CPN visits and facility deliveries but noted periodic stockouts. Although they confirmed that the last mass distribution was in 2022, some complained that distribution was inequitable, with households with the same number of inhabitants receiving different numbers of bed nets. Women from the HPHA reported that their bed nets were easily torn or eaten by rats and were generally in poor condition, and as a result, many children did not sleep under a bed net. Women from the LPHA claimed that although they used bed nets, malaria persisted, leading them to believe that malaria was not transmitted by mosquitos, but was caused by poor nutrition or working in the marsh.

Vaccinations

Both HCs offered child vaccinations monthly during CPS and during outreach visits in distant villages, although the frequency of outreach visits appeared to be irregular. HCs had a functional refrigerator and cold chains, which was a new development since the midline evaluation, when ITs reported challenges ensuring that children were fully vaccinated. However, the cold chain in the LPHA was not working at the time of the evaluation because the HC was under construction. Informants consistently mentioned improvements in vaccine availability and acceptability, with some noting that child vaccinations had become more routine, adding that awareness raising had been effective in improving knowledge about the importance of vaccines. One RECO claimed that sensitization offered through the VIVA campaign contributed to improved acceptability of vaccines. The CODESA President from the HPHA said:

> *Many have changed their behavior, before some people thought that vaccines kill children or create problems, but once they understood the reality they no longer refused.*

The IT from the LPHA said:

> *I don't have a precise figure, but the results are positive. Mothers are following the vaccination schedule, the CPS is working, the CACs and relays are raising awareness, and we don't really have shortages of vaccines. We are on the path to performance. Before, mothers were afraid to bring their children for vaccines. This is no longer the case.*

Informants also noted that mini-campaigns, involving the identification and administration of vaccines to children who had not been vaccinated or missed vaccines, had helped increase vaccination coverage. During these sessions, community agents might administer oral vaccines, or the child was sent to the HC for vaccines administered with a syringe. Informants recognized that USAID IHP efforts contributed to improved vaccination rates.

Challenges included periodic vaccine stockouts, especially of the BCG vaccine, which could last for several weeks or even months. Other vaccines reported to experience stockouts included the measles and tetanus vaccines. One CODESA President mentioned that some people were still concerned about vaccine side effects, such as fever and swelling.

Women in both groups reported that their youngest child was up to date with vaccinations, except for the BCG vaccine, which the women confirmed experienced regular and long stockouts. The women appreciated the role that vaccines played in protecting young children from severe illness, with many able to name the vaccines and when they were offered to young children. A participant from the LPHA said:

> *My paternal uncle had seven children. Not knowing anything about vaccines, none of his children were vaccinated, and all his children died. Today, if a vaccination is announced and he doesn't find you at home waiting for it, he will beat you!*

Women in the HPHA group reported that few children in their village missed vaccinations whereas women in the LPHA acknowledged that some families continued to hold beliefs that opposed vaccinations and negatively influenced acceptance. Focus group participants in the LPHA reported recent vaccination campaigns for measles (October 2023) and polio (March 2024), whereas in the HPHA, women mentioned a campaign for the oral polio vaccine. Focus group participants in the HPHA mentioned that the HC had recently received materials for the cold chain that had not been installed due to lack of space, adding that vaccines were obtained from the BCZS. Women in the LPHA also reported that the cold chain was not functioning, forcing health personnel to get vaccines from the BCZS.

VIVA Approach

Walungu is one of the HZs where BA piloted VIVA interventions. Informants spoke highly about the interventions and their impact, claiming that a wide range of health themes were shared in an understandable and enjoyable way, and that the interventions improved household practices and boosted the use of health services. Informants claimed that both men and women engaged in the interventions, which used innovative approaches to community education, with all informants noting that the distribution of materials, such as soap and certificates, encouraged participation. They added that VIVA provided money to community health actors, including 100 USD for monthly CODESA committee operations, 100 USD to CAC committees to assist villagers unable to pay for healthcare, and monthly transport money to RECOs. Informants mentioned that community actors were involved in the development of activities and received extensive training, and that the

campaign offered new approaches and materials to lead awareness raising, which attracted people's curiosity.

Informants reported that once BA was no longer involved in field activities, which occurred more than a year before the endline evaluation, incentives were removed and the interventions stopped. The IT from the HPHA said:

> *With VIVA, the activities worked normally because there was soap distributed after the educational sessions, there was a little motivation for the RECOs. After they abandoned that, activities were no longer sustained as in the past. Our community members find it difficult to participate for free.*

The CODESA President from the HPHA said:

> *When BA said they will no longer continue with us, and that it is PROSANI who will take the baton of control, we no longer saw PROSANI. I even thought that PROSANI no longer existed, until recently in 2023 when equipment arrived in the HC with the USAID stamp, even a refrigerator for the cold chain. VIVA did not last, because it was given to PROSANI, but PROSANI never showed up on the ground, PROSANI was supposed to lead the activities, but representatives have never been in the field.*

A RECO from the LPHA said:

> *VIVA is no longer active because the motivation was removed. People are forgetting about community relays; we are told that a community relay does not have a salary and is a volunteer. There are community relays who cannot accept that, they prefer to engage in activities that can generate money for his family, but if there is a little motivation we carry out our activities.*

Community Health Worker Motivation

Several informants reported a decrease in the engagement of CHWs, attributing the change to the removal of financial incentives introduced by IPs, with some citing the VIVA campaign. When asked about the sustainability of CHW activities after the completion of USAID IHP, the IT from the HPHA said:

> *I don't know if they will continue activities, because they don't like working for free anymore. You will even find in mass vaccination campaigns, once certain RECOs are not paid, there are problems. I don't know what we will do at the end of this project…. With VIVA, the activities worked normally because there was soap distributed after the educational sessions, there was some motivation for the RECOs. After they abandoned that, these activities were no longer sustained as in the past. Our community actors really find it difficult to accept working for free.*

A RECO from the same HA said:

> *There are community relays who are starting to be lazy. When BA started with CACs, the RECOs were very active because there was motivation, but when there was no motivation, some began to decrease their pace. No one supervised and no one requested the reports, it was only the CODESA President who did that. Then the others*

noticed that there was no longer a motivation. If there is no motivation, not everyone will be active, but if there is motivation everyone will participate.

When asked whether the training offered by USAID IHP motivated them, informants acknowledged that it increased their knowledge and allowed them to collect per diem, but several mentioned that training was no longer offered. The HPHA RECO said:

Raising awareness on disease prevention gives good results. but we cannot raise awareness every day without a little motivation. We leave our household activities, and when we return home, the children must eat. If we are given motivation we will raise awareness, but when we are neglected, it discourages us…An IT who does not get paid will not provide good care.

CHWs also expressed discouragement due to false promises about compensation. For instance, although they were supposed to receive a percentage from the AAP PBF approach, this was not being honored, and when they participated in campaigns, they were frequently not paid as promised.

Although CHWs acknowledged that they had agreed to work as volunteers, all informants asserted that monetary support would ensure sustainability. The IT from the LPHA said:

Awareness raising is producing good results in the interest of the population. This will not stop, it will continue. So, there will always be awareness raising in families, in schools, in churches, in health centers. But with motivation at the relays, sustainability will be more assured.

Perceptions of USAID IHP

Facility-based providers reported training and provision of medications and equipment as the greatest contributions, with some adding that these activities had increased quality of care, service use, and health facility revenue. Two informants mentioned that zonal monthly reviews sponsored by USAID IHP had facilitated improved access to and the quality of health information. Although these changes were considered positive, informants reported that facility revenue remained very low, and health workers would not be satisfied until they were remunerated appropriately. There was consensus that assistance, especially training, provided by USAID IHP had sharply decreased since the midline evaluation, and that USAID IHP staff were no longer present during monthly reviews or in the HZ.

Informants working in the reference hospital expressed frustration that USAID IHP focused mainly on obstetric services and neglected to support pediatric care. At the same time, they acknowledged that training and the equipment provided introduced important lifesaving improvements to obstetric care.

There was also mention of improved preventive services. Informants reported training sessions offered to CHWs, especially by VIVA, that enhanced awareness raising and, in turn, influenced increased health service use, especially related to maternity care and vaccinations. Some informants considered the campaigns designed to identify and refer children who had missed vaccinations to the HC as highly effective. Community agents lamented that USAID IHP had failed to continue VIVA interventions, which informants considered to be effective. Head nurses raised concerns about the sustainability of volunteer CHWs, mentioning that community actors were disgruntled, causing a recent drop in community activities.

Informants stated that they would continue both facility- and community-based activities after the

discontinuation of USAID IHP assistance, with several highlighting that improvements gained through training would be sustained and the equipment received would be well maintained. Several mentioned that they were accustomed to partners transitioning, with the IT from the LPHA stating:

> *Partners come and go one day. InterSOS [an IP] is gone, now we have AAP, which will also leave. In any case, we will do everything to safeguard what we received from USAID IHP. We will keep the materials and equipment received like a good father…. We are not going to fold our arms; we will do what is necessary.*

Sud Kivu: Miti Murhesa Health Zone

Facility-Based Services

Infrastructure

Health Centers

The HPHA included eight villages and an HC located three kilometers from the reference hospital. Constructed in 1948 and originally a health reference center, the HC was comprised of several concrete buildings, including a maternity ward. The center was supplied with power from the government-run electrical company and rented solar panels to supply electricity during power outages. The HC had tap water provided by the government water system and had a working laboratory and incinerator. The HPHA started receiving support from the World Bank PBF approach about a year before the evaluation.

The LPHA consisted of 12 villages and an HC located about 22 kilometers from the reference hospital in an isolated, hilly area. Constructed in 2010, the wooden structure leaked and had cramped quarters, forcing workers to treat adults and children in the same room and making it difficult to assist deliveries. In 2020, the Global Fund promised to finance the construction of a new HC, and in response, the community obtained land about five kilometers from the current HC. In 2024, another IP confirmed plans to build a new center, but at the time of the endline evaluation, no progress had been made on the construction of a new HC. The HC purchased solar panels to generate electricity and used a storage tank to collect rainwater; the HC did not have a functioning laboratory or incinerator. The LPHA did not receive support from the World Bank PBF approach being implemented in other health areas in the Miti Murhesa HZ. One informant claimed that only HCs near the main town received support from IPs, adding that HC workers wondered whether they were still considered part of the Miti Murhesa HZ.

General Reference Hospital

The reference hospital became operational in 2014, but according to informants, was in need of renovations and construction of additional buildings so that key services, such as surgery and internal medicine, could operate in separate buildings. Key informants mentioned that quarters in the pediatric ward were too cramped to comfortably accommodate all patients, and that a separate area for neonates was not available.

Services Offered

Health Centers

Health services included outpatient consultations, 24-hour observations of sick patients, and basic surgery, with the HPHC maintaining a functional laboratory and offering treatment for malnourished children. The mandate of the IP supporting treatment of malnourished children in the LPHC had ended, and the

replacement IP only assisted HCs supported by the World Bank. The LPHC IT reported that the HA had high rates of malnourished children, who he referred to other facilities providing treatment for malnourished children, stating:

> *We no longer have a partner that supplies for treatment of malnutrition…These inputs are only given in structures that have the support of the World Bank. I refer malnourished children to structures that have treatment supplies, sometimes they deceive me by making me believe that they are going to the health centers, but then they don't go. We see many malnourished children, but we cannot take care of them. Many sick children arrive whose main diagnosis is malnutrition, they arrive with a cough and fever, but you find that they are extremely malnourished, so even if you treat the child, you are not going to succeed because he needs nutritional treatment.*

The fact that the LPHC did not receive World Bank support, which involved reduced consultation fees and free maternity fees, negatively affected the use of health services, with community members opting for HCs with less expensive care. The IT reported that patients, who assumed that the IT was deceiving them, applied pressure for reduced fees that corresponded with fees charged at other HZ facilities.

ITs reported that health personnel continued to follow flowcharts for treatment of childhood illnesses based on training received from USAID IHP before the midline evaluation. The IT from the HPHA emphasized the importance of the IMCI training and flowcharts, that they had helped health workers identify danger signs, treat patients, and know when to refer both newborns and children to higher-level facilities. ITs reported following IMCI protocols on the integration of curative and preventive care, adjusting prevention counseling according to the illness. For instance, health workers informed caregivers of children diagnosed with malaria about the importance of removing stagnant water from the family compound and ensuring that the child slept under a bed net. The head nurse from the LPHC reported that USAID IHP had emphasized the importance of preventive counseling during treatment consultations.

Promotional services devoted to women and children involved CPN, CPON, and CPS, comprised of growth monitoring, nutritional counselling, administration of vaccinations, distribution of insecticide-treated bed nets, administration of mebendazole and vitamin A, and education sessions focused on prevention of childhood illnesses. The IT from the LPHA did not appear to understand that CPS was supposed to continue beyond when the child reached nine months of age. The same IT mentioned that they offered CPS in all 12 HA villages monthly, and that health workers periodically traveled to remote areas to administer vaccines. The IT from the HPHA mentioned changes associated with CPS revitalization involving monitoring of children's growth up to 59 months of age and community-based screening for child malnutrition. He reported biweekly CPS sessions at the HC, as well as regular outreach visits to villages. Challenges mentioned included stockouts of BCG, and sometimes the yellow fever and varicella-zoster vaccines, and inadequate CPS forms.

Focus group participants from both HAs mentioned that they sought curative care for diverse illnesses, especially malaria, and used the HC maternity services. Women from the HPHA added that the HC had a laboratory to diagnose illnesses, which increased their confidence in the care. Participants in both groups expressed pride and appreciation for the way that they were treated at the HCs. One participant from the HPHA said:

> *We go there out of love for our clinic. I like how they care for us; it is not the way we are received at other health facilities.*

Another woman from the same HA said:

> *We usually come here because we like the way we are received, we are in a bad environment with many illnesses, but here, they try to take good care of us.*

Attendees of focus groups mentioned that during treatment consultations and CPS they were exposed to information on the importance of good nutritional intake, childhood vaccinations, attending CPN, protecting children against common illnesses, including the use of bed nets, good hygiene and sanitation in family compounds, and using formal health services.

Reference Hospital

Hospital services mentioned included internal medicine, surgery, maternity care, pediatrics, free treatment for acute severe malnourished children, laboratory services, and imaging. Hospital staff reported that child treatment started with neonates, who were treated in the pediatric ward because there was no designated area for neonates. Hospital workers followed emergency neonate and pediatric and urgent pediatric protocols developed by the DPS in Sud Kivu for common pathologies, such as malaria, diarrhea, and pneumonia, with one informant reporting that these protocols were followed scrupulously to ensure that sick children were managed appropriately. Interestingly, hospital workers reported that they had never been trained on IMCI and did not follow IMCI flowcharts. Preventative counselling related to childcare occurred during treatment consultations and CPN offered at the hospital, and with women waiting for delivery and during CPON, although hospital workers indicated that they focused mainly on treatment. The medical doctor emphasized the importance of preventive care, adding that many patients did not frequent HCs and recommending that the hospital introduce more preventive services, such as bed net distribution. He recommended that an HC always be next to the hospital to ensure complementary preventive care, noting that the closest HC to their hospital was three kilometers away. Informants mentioned that the hospital was missing some key services, including physiotherapy, ophthalmology, and dentistry, as well as a morgue.

Equipment

Health Centers

Since the midline evaluation, the HPHC had received extensive equipment from USAID IHP, with the IT mentioning receipt of maternity kits, a delivery table, adult and children scales, blood pressure monitors, stethoscopes, vital sign monitors, timers, microscopes, and fire extinguishers. The IT in the LPHA was aware that USAID IHP had distributed equipment to other HCs, which his HC had not received.

Both HCs had functioning refrigerators and adequate beds and mattresses for sick patients under observation and in the maternity ward. However, due to the cramped quarters, the LPHC had problems accommodating beds and other new equipment recently received from another IP, with informants adding that the metal bed frames sunk into the dirt floor.

Neither HC had a consultation table for infants and children. Both HCs had basic equipment, such as thermometers, stethoscopes, blood pressure monitors, thermometers, and timers, although the sterilization equipment did not function properly and needed to be replaced. The HPHC had newer and more materials, whereas the IT from the LPHC stated that many materials were old and needed to be replaced. The HPHC had new scales for newborns and infants, hanging balances with trousers for small children, and height measures, whereas the IT in the LPHC indicated that the adult and child balances did not give accurate information. The

HPHC had two functioning microscopes, one of which was recently provided by USAID IHP, whereas the microscope in the LPHC did not function properly.

The IT in the HPHC reported the need for a heating table for newborns, an electrocardiogram machine, and incubators. The IT in the LPHC suggested that the center needed a second delivery kit, stating that multiple births could occur simultaneously, forceps and scissors for minor surgery, as well as an otoscope.

HCs purchased new materials with their own funds, and when more expensive equipment was needed, they sent a request to the BCZS or made their needs known to IPs during meetings at the BCZS. When equipment needed repair, they contacted local technicians who they paid using HC revenue.

Reference Hospital

Informants were aware that the hospital had received equipment from USAID IHP since the midline evaluation, but were unable to specify what equipment, although one informant mentioned a refrigerator. Hospital informants reported maintaining basic equipment for the treatment of children, including pediatric blood pressure monitors, pediatric pulse oximeters, oxygen concentrators, and an incubator. The hospital had scales for newborns and infants, and height measures. Hospital informants reported 25 beds available in the pediatric ward to accommodate 75 patients, on average, forcing three children to share one bed, and adding that the limited quarters in the pediatric area could not accommodate more beds.

Equipment needs mentioned included additional oxygen concentrators, a circuit for anesthesia in the operating room, an ultrasound machine, incubators, a functioning electrocardiogram machine, an autoclave for the laboratory, and a new X-ray machine, with informants reporting that the machine they had produced poor quality results. Hospital staff include equipment needs in the annual workplan or inform the BCZS and IPs. If the requests go unmet, the hospital might purchase equipment locally depending on the availability and price. When equipment broke down, it was the responsibility of the hospital to identify a technician and pay for repairs.

Medication

Health Centers

As was the case during the midline evaluation, head nurses reported ongoing stockouts of medications. The head nurse of the HPHA stated that monthly drugs provided by the BCZS responded to 60 to 70 percent of their drug requests, forcing the HC to purchase drugs from local pharmacies. Drugs mentioned that had regular stockouts included anti-malarials and zinc, as well as rapid malaria tests. The IT said that USAID IHP covered 70 percent of the costs for the drugs they delivered, and that the medicines supplied by USAID IHIP were of high quality and within the expiration period. The IT in the LPHA reported that monthly drug requisitions to the BCZS depended on HC savings available at the beginning of the month, which were often limited or unavailable, allowing the HC to purchase only small amounts of drugs, and forcing the IT to purchase drugs locally or to give patients prescriptions. The IT mentioned experiencing frequent stockouts of intravenous drugs, glucose, antibiotics, including amoxicillin, and anti-malarials, adding that he often used the anti-malarials given for CPN visits during treatment consultations. This IT, who had arrived 18 months before the endline evaluation, claimed that since his arrival, the HC had never received medication from USAID IHP. The HC was not receiving support from the World Bank, and according to the IT, had not received any IP drug support since August 2023.

The IT from the HPHA appreciated the USAID IHP last mile approach, stressing that USAID IHP encouraged

community ownership of health activities. He added that the approach saved health staff time and decreased the likelihood of theft during drug transport from the BCZS to the HC.

Reference Hospital

Hospital informants reported that 20 percent of revenue was allocated for drug purchases that were made monthly. In addition, the hospital received medications from IPs, including the World Bank and USAID IHP, but informants reported that drug deliveries were irregular, often arrived late, and were provided in quantities that fell short of the hospital requisitions. One informant mentioned that they often received drugs that they did not order, or that were about to expire, and large quantities of drugs that were less used. High use of services, along with the fact that drug provided by donors did not conform with their orders, led to ongoing stockouts, forcing the hospital to replenish stocks from pharmaceutical depots in Bukavu, about 25 kilometers from the Miti Murhesa HZ offices. The medical doctor working in the pediatric ward mentioned that the hospital especially experienced stockouts of specialized children's medications, adding that the biggest challenge was maintaining safe blood for transfusions. Informants noted that USAID IHP distributed high-quality drugs, but in small quantities.

Use of Services

Informants from the HPHC reported an uptake in the use of services, which informants attributed to the reduced fees and free care for indigent community members implemented by the World Bank PBF approach. The LPHC, which maintained higher fees established years earlier with help from USAID IHP, appeared to be seeing fewer clients because community members opted to go to facilities supported by the World Bank program that offered reduced fees. In this HA, informants cited poverty as the biggest obstacle to healthcare use, although the head nurse mentioned that they treated patients on credit.

Other constraints cited by head nurses, CODESA members, and RECOs were similar to those collected during the midline evaluation, and included opposition to biomedical care by religious leaders, visits to prayer rooms, self-medication with locally available pharmaceuticals, and care seeking from traditional practitioners who offered treatment that corresponded with local belief systems. The practice of cutting tonsils was mentioned as a common and dangerous practice provided by local healers. Informants reported that use of alternative treatment sources resulted in dangerous delays in reaching health facilities and often exacerbated health conditions. When talking about prayer rooms, the IT from the HPHA said:

> *The prayer rooms are very, very numerous. There are sects where sick patients are kept, before people go to the hospital they have to pass there. Caregivers are told, 'Those are the evil spirits, the devil who causes the child to convulse, you must not take the child to the hospital, the child is taken by evil spirits. Before going to the hospital, go to the pastor who will pray for the child.' The child will spend two days there, and they will bring the child when it is in a very bad condition…. Some end up dying, because the patient has spent a lot of time in the prayer rooms, and when he arrives [at the hospital] it's already too late. For what? Because the pastor wants to show that God will act, and the spirits have fled.*

Distance and poor roads, especially during the rainy season when mud could cause slippery and dangerous conditions, was cited as another obstacle, especially in the mountainous and isolated LPHA, where villages were dispersed and distances long. The IT in the HPHC also mentioned that poor reception by the health worker staff could affect healthcare use, stating:

Some people go to other places because the health workers are not very welcoming. Poor reception can cause people to change their choice of provider; there are patients who avoid the HC because unwelcoming providers work there, there are patients who are afraid to come because of this or that provider. These are state agents who we cannot fire due to their behavior. We sanction, we repress, there are letters, there is correspondence, and we hope that these agents will be transferred.

The IT in the LPHC considered the condition of the HC—which was made of wood, was small, and leaked when it rained—as a major deterrent to care seeking from the HC.

Regarding the USAID IHP contribution to increased service use, the IT from the HPHA mentioned that initially USAID IHP supported negotiations between community members and health officials to reduce consultation fees. He added that USAID IHP had provided "hard to find supplies," such as quality drugs, rapid malaria tests, and equipment, including motorcycles, which improved operations and were difficult for facilities to obtain, as well as indispensable technical support to health services, such as CPS, CPN, and IMCI. However, he noted a recent decline in USAID IHP visibility and assistance. The IT from the LPHA only mentioned that USAID IHP helped increase healthcare use by assisting with negotiations for reduced fees, adding that these fees were now higher than those offered at Word Bank-supported facilities. He noted that USAID IHP had requested HAs to establish lists of vulnerable people eligible for cheaper or free care, but that no subsequent support for indigent villagers had been provided.

The hospital informants mentioned that service use was increasing, which they attributed to reduced hospital fees and increased access by vulnerable patients due to free care supported by the World Bank, along with the recent government initiative to offer free maternity care. They also mentioned that internal efforts to use generic drugs, and the fact that USAID IHP subsidized drug costs, helped maintain lower costs for patients. The doctor informant mentioned that although health mutuals were being introduced, uptake was very low.

Focus group attendees from the HPHA most frequently cited the lack of financial means as the biggest obstacle to access to healthcare, with participants adding that people were often forced to discontinue treatment because healthcare became unaffordable. Many women from the HPHA mentioned that the HC often lacked medications, which patients must purchase from pharmacies, preventing people without money from complying with drug regimens. One woman said:

It is the lack of means, money. You find yourself at home, you have nothing to eat, you do not even have 100 Congolese Francs, when you fall ill. It may have to borrow money to get care. You may not find medicines at the health center and be asked to buy drugs at the pharmacy. The patient may even die while getting care in the dispensary, hence the decision to keep him at home, because it is better to die at home than to get into trouble due to lack of money.

Another woman added:

They take care of you for the first week, the second week they will ask you for money and when you show that you do not have any, they stop taking care of you. People spend months looking for the money they owe the hospital. You will end up borrowing money and paying to get out, and the next time you return to the health center they will not care for you as the first time…A child from our family came here three times and the

fourth time when his maternal aunt saw that she no longer had any financial resources, she returned home, and the child ended up dying.

Women from the LPHA focused on the poor condition of the HC, which was built of wood; inadequate equipment, including an insufficient number of beds, forcing patients to share beds; lack of adequate light and water; limited supplies, such as sheets and blankets to cover women after delivery; and insufficient space to accommodate patients, which was also a problem mentioned in the HPHC, as was the lack of water. The LPHC participants lamented that the HC, located on a hill, was difficult to access, and that they had to pay for delivery care, which was free at other centers. They added that the head nurse refused to provide treatment on credit, noting that other facilities offered better care.

Focus group participants from the HPHA mentioned many other healthcare options, including self-medication, care seeking in prayer rooms, and ingesting traditional remedies. Women from both HAs suggested that health workers recommended attending prayer rooms after receiving biomedical treatment, with one woman stating:

Some people go to prayer rooms rather than going to the health center. There are even patients who are directed by the nurses to pray and to subsequently come back to continue with the medical care in the center.

Another participant said:

My child suddenly fainted and lost consciousness. For such cases, the nurse can recommend that you take the child for prayers, then bring him back to continue with the health center care. However, there are cases where the child is brought to the prayer room when he has severe malaria and needs blood and the child will die, although he would have lived if he had been in the hands of the nurses.

Generally, focus group participants from both groups were reluctant to share information on the use of non-facility care, with women in the LPHA suggesting that these forms of care were shown to be less effective and had negative consequences. Women participants in the LPHA reported that there were many other health facilities in the area that had better services, and even free delivery care, but that strong encouragement by community health actors had encouraged them to continue to use the HC services. One woman said:

A sensible person would say that I am not going to [the LPHC], because it is not well built, but by continuing to attend the center that we can attract a partner who will help us build a new center.

Management and Governance

Coordination

Health Centers

As reported during the midline evaluation, ITs participated in monthly zonal meetings that included BCZS personnel, hospital staff, ITs, and IPs. The IT from the HPHA reported that USAID IHP staff previously participated in these meetings, but that they no longer attended. The same IT mentioned that CODESA Presidents attended monthly meetings, an approach promoted by USAID IHP to ensure that community perspectives on health indicators and community challenges were represented during meetings.

According to informants, meetings involved the review and validation of HA health indicators, also mentioning

that they discussed issues related to HA management, the receipt of medications, zonal policies, the evolution of health indicators, and successes and challenges in their ongoing activities. ITs agreed that monthly meetings presented opportunities to exchange information and learn from counterparts, which could help strengthen both facility and community activities.

Other forums reported to facilitate exchanges of information across layers of the hierarchy included training workshops, meetings organized by the DPS involving different HZs and donors, or briefings led by the BCZS or DPS before mass campaigns, new activities, or urgent events, such as outbreaks. The IT from the HPHA reported participating in exchange visits involving staff from one health structure visiting another facility to observe work conditions and exchange information on effective approaches and difficulties faced. He added that USAID IHP sponsored this activity to promote learning, adding that with reductions in USAID IHP funding, these types of activities had decreased. Some noted that the health system followed a strict hierarchy, which restricted opportunities for HA CHWs and providers to share information with DPS and IP staff.

Informants made little reference to monthly HA meetings, which were attended by facility staff, CODESA members, and some RECOs. During HA meetings, data were compiled and prepared for the monthly zonal monitoring meeting. There was also little mention of monthly CODESA committee meetings, which were sponsored by USAID IHP.

All types of HA informants reported participating in occasional meetings devoted to community development, such as road maintenance, village sanitation, or construction of a new HC, with the IT from the HPHA attributing a greater emphasis on community development to support from USAID IHP.

Reference Hospital

Hospital informants mentioned that they collaborated with HCs, the BCZS, and the DPS, with the hospital staff primarily reporting to BCZS personnel. Hospital workers described collaboration with the zonal staff as positive, with one informant stating that whenever partners visited, BCZS staff encouraged them to meet with hospital workers. One of the hospital informants was a member of the zonal management team in charge of supervision of primary health structures, which met weekly. Reported meetings with the DPS or HZ staff involved the BCZS board of directors meeting held twice annually and chaired by the DPS; management board meetings of the BCZS; meetings devoted to the development of the zonal and reference hospital *Plan d'Action Opérationnel* (PAO, Annual Operations Plan) involving DPS staff; training and briefings related to special events, such as campaigns; and monthly zonal meeting attended by ITs, hospital physicians, and the hospital nursing director at which participants reviewed facility data and also discussed the status of referral patients.

Hospital informants had never participated in meetings focused on community development.

Accountability Mechanisms

Health Centers

Accountability mechanisms had changed since the midline when they had primarily involved suggestion boxes and one-on-one interactions to address problems. In both HAs, health personnel and CODESA members had received training in early 2024 led by USAID IHP on the community scorecard (BCP) approach, with informants indicating that the approach aimed to increase the interface between health workers and community members and improve oversight of HC activities by community members. The HPHA had developed a strategic plan and initiated BCP-related activities, although the plan was not posted in the HC. This IT underlined the benefits of collaboration with community members to identify and address problems,

adding that the approach encouraged concerted development and cohesion. Since the training, the LPHA had done little to move BCP activities forward.

The HPHA maintained two fraud and abuse accountability hotlines, with one supported by UNICEF and the second financed by USAID IHP. The IT expressed concerns that the tollfree lines could be used by people with negative, and unjustified, intentions, stating that the USAID IHP line was primarily for RECOs to use. Neither telephone numbers were posted, and we were told that the numbers were not widely shared. The LPHA had a line introduced in February 2024 by another project but not by USAID IHP; once again the number was not posted or widely disseminated. Informants indicated that the greenline was used to share problems detected at the HC with higher authorities.

The HPHA had two suggestion boxes, with one introduced by the World Bank, whereas the LPHA had one suggestion box. Informants reported that at the time of installation, community members were informed about the availability and purpose of the suggestion boxes, which was to allow clients to submit suggestions to improve services. The IT in the HPHA considered the suggestion box as a mechanism to keep health worker behavior in check and decrease health worker-patient confrontations, although he mentioned that complaints submitted could escalate miscommunication and distrust. The data showed infrequent use of the suggestion boxes due to concerns about repercussions for submitting complaints, as well as widespread illiteracy.

Key informants also mentioned that RECOs and CODESA report negative attitudes and practices exhibited by health providers during CODESA meetings, which were subsequently discussed with the head nurse who may call a meeting with the HC health workers or speak directly to the person exhibiting bad behavior. Informants agreed that negative attitudes and inappropriate behavior could negatively affect healthcare use. One RECO from the LPHA said:

> *If health providers display bad behavior toward patients, attendance will decrease, this is why we give them advice on their behavior. If the nurses use nasty words and behaviors, the patients will go elsewhere.*

Overall, informants appreciated the need to improve accountability of the health workers by encouraging transparency and monitoring by community members, which some stated had recently increased. However, accountability mechanisms did not appear to be implemented as planned, raising questions about their effectiveness. Informants mentioned that the sustainability of the community scorecards, an approach that did not need much external support, depended on the extent that health workers and community members took ownership of activities. They considered the greenline, which involves the IPS offices, an approach that would be managed by the government.

Reference Hospital

The hospital posted a suggestion box to monitor negative attitudes or practices exhibited by health providers. Neither a telephone line nor community scorecards had been introduced. The hospital administrator also mentioned that the IPS teams encouraged health workers to denounce bad acts during visits to the hospital, and that the hospital administration frequently reminded staff about the importance of following good ethics and adhering to internal regulations.

Health Financing

Health Centers

Healthcare financing had changed in the HPHA since the midline evaluation due to the introduction of the World Bank PBF approach, which was instituted about a year before the endline evaluation. Theoretically, the World Bank approach provided quarterly payments based on facility performance, while at the same time requiring that the HPHC reduce consultation fees and provide free care to some vulnerable community members. The IT noted that the HC, which was supported by the Catholic Church, had a philosophy of assisting indigent community members, but that the number of people had increased with the start of the World Bank approach, adding that the number of daily consultations had also increased dramatically. In addition, USAID IHP subsidized drug costs and provided essential, and often hard to find, equipment and supplies, which helped the HC maintain low fees. When talking about USAID IHP, the IT said:

> *PROSANI supported the health zones and our structures for a long time, although after a certain time we found that the interventions were reduced. After PROSANI, we do not know whether another partner can take over because we received hard-to-find inputs [supplies and equipment] thanks to PROSANI.*

The LPHA, which was not supported by the World Bank, maintained flat consultation fees previously negotiated with community members through support from the BCZS and USAID IHP to make healthcare more affordable. The LPHC fees were high compared with the surrounding HCs supported by the PBF approach, thus making the LPHC less competitive to attract clients. This, along with the poor state of the wooden structure, and the fact that the facility had not received new equipment distributed by USAID IHP, was contributing to reduced use of the facility, which was located in an isolated area and frequented by residents who primarily relied on subsistence farming. The IT mentioned that he treated patients on credit but added that they were often unable to pay back the debt. As indicated, USAID IHP had previously told the HC to identify vulnerable members eligible for free care, but no subsequent support had been offered by USAID IHP or other partners to assist indigent members. Interestingly, neither facility posted the set healthcare fees.

The only other financial approaches mentioned included health mutuals, especially a health mutual for teachers that was supported by the government. ITs affirmed that the concept of health mutuals was poorly understood by most community members.

Reference Hospital

With the start of the PBF approach, hospital informants reported instituting reduced flat consultation fees established with community members, and free and reduced care for indigent citizens, which resulted in improved hospital use compared with previous years. However, the medical doctor claimed that many of the identified indigent members were family members of CHWs, adding that the CHWs felt entitled to help family members as a form of compensation. The medical doctor noted that hospital revenue did not allow workers to render decent salaries, adding that the recent institution of free maternity care had further reduced hospital revenue. To keep costs down, the hospital primarily purchased cheaper, generic drugs. He added that USAID IHP contributed by covering 70 percent of the costs of the drugs they provided, but that medications provided by USAID IHP were minimal compared with the hospital's needs.

Hospital informants mentioned that the hospital accepted patients participating in health mutuals, citing a government-supported approach for teachers and a mutual for community members supported by an IP, adding that participation was very low. The hospital also accepted bonds from patients working for agencies,

such as the Kahuzi-Biega National Park.

Resources for Facility Workers

The personnel of the HPHC included the head nurse who was at the A0 level; six A1 staff, including three midwives and a lab technician; four A2 nurses; seven A3 workers, including traditional birth attendants and aides; and an accountant. In the LPHA, there were two A1 level nurses, including the head nurse; two A2 staff, including a birthing attendant; an A3 worker; and a laboratory aide.

Training

Health Centers

Head nurses reported that HC personnel, especially from the HPHC, had participated in many training workshops over the past year covering diverse themes, including maternity care, FP, gender-based violence, IMCI, WASH, and nutrition, with community scorecards the only training mentioned that was supported by USAID IHP. Typically, one or two health personnel were invited to attend training sessions, and those people who were trained were supposed to share knowledge obtained with other workers in the same facility, although our data suggest that follow up briefings were not always carried out and might be inadequate. Head nurses stressed the importance of training opportunities during which health providers were exposed to innovations and increased knowledge, all of which impacted on the quality of healthcare.

Both head nurses mentioned that USAID IHP offered far more training before the midline evaluation. They stressed the high quality of USAID IHP training, which they mentioned involved practical sessions, which allowed participants to apply newly introduced practices in work environments. They also mentioned receiving standardized data collection tools, modules, and other instruments during training, which facilitated the harmonization of treatment approaches.

Reference Hospital

Hospital informants reported that hospital staff had recently participated in training sessions related to maternity care, TB, integrated management of malnutrition, FP, and pediatric protocols for urgent cases. Two of the three hospital workers trained in pediatric protocols were recruited for other jobs subsequent to the training. Although hospital informants reported that USAID IHP had offered many training sessions before the midline evaluation, they did not report any training recently organized by USAID IHP. Although they valued training opportunities, which they stated allowed them to obtain new information, hospital informants lamented that few health workers were invited to attend training workshops.

Supervision

The head nurses reported receiving supervisory visits by the BCZS at least monthly, with the IT from the LPHA mentioning that the focus was often on childhood vaccinations and nutritional intake of young children. HC workers reported that DPS personnel carried out supervision once a semester, which they characterized as an inspection.

BCZS staff were reported to carry out integrated supervision of all hospital services one to two times a year. Informants indicated that supervisors identified positive and negative aspects of services, leaving a list of recommendations at the facility for health providers to address before the next supervision visit. In addition, hospital informants reported receiving clinical coaching visits by DPS staff. Although hospital workers indicated that USAID IHP had previously conducted supervision visits, no USAID IHP staff had visited in the past year. The administrator recognized that USAID IHP provided financial support to the DPS and BCZS for

supervision.

Access to Continuing Education

Health Centers

Similar to reports during the midline evaluation, informants stated that the primary way to receive information was through training, emphasizing the need for increased access to health-related information to improve the quality of health services. The IT in the LPHC appreciated the learning materials, such as modules on SNIS data entry, distributed by USAID IHP.

Reference Hospital

The evaluation team did not question hospital workers about access to information. This information was collected in the Walungu HZ.

Attitudes of Health Workers

Health Centers

Both head nurses reported cases of health personnel exhibiting inappropriate behavior during work. Offenses mentioned included speaking inappropriately to colleagues, insulting patients, or illicitly collecting money from patients for services. The head nurse in the LPHA mentioned that negative interactions with patients most often occurred over questions about service invoices.

Head nurses stressed the importance of addressing improper behavior quickly by talking to the concerned workers and taking action through warnings, sanctions, or requests to transfer the staff member, depending on the offence, adding that poor health personnel behavior could negatively impact healthcare use. The IT from the LPHA also stressed the need to communicate with the community when an offence had occurred to alleviate concerns. There was little mention of the use of accountability mechanisms, including BCP, suggestion boxes, or the greenline, to report inappropriate attitudes or behaviors.

Both head nurses stressed the importance of maintaining good communication with staff members and CHWs, and reinforcing commitments to adhere to government rules and good ethics, although the ITs admitted to having received minimal training related to health worker behavior. The exception was HPHA birth attendants, who had received training from USAID IHP on being empathic and providing physical contact during delivery.

Reference Hospital

Hospital informants reported times when health workers expressed frustration and anger with patients. They considered unequal pay, mentioning that some workers receive government salaries and bonuses and others do not, and poor remuneration as the main reasons for outbursts during work. The doctor reported that three hospital workers had been suspended for three months in 2023 for missing work and working while inebriated.

Health Worker Sources of Motivation

Health Centers

HC workers relied on facility revenue for remuneration, which was divided according to a fixed formula designed to cover operational costs, with a percentage allocated for health worker salaries. Workers in the HPHA also received quarterly payments from the World Bank based on individual performance. None of the workers in either structure received government salaries, and only a small fraction received risk bonuses. The IT in the LPHA mentioned that their conscience also motivated health workers to carry out their work, despite

the low remuneration.

Both HCs reported offering flat consultation fees, although the fees were not visible during our visit. The LPHA fees were initially established at a time when USAID IHP was promoting flat, negotiated fees, whereas the HPHA had introduced even lower fees with the performance-based approach. Although the IT in the HPHA reported that the lower fees had increased service use, the World Bank also required that health workers get a reduced percentage (from 60% to 40%) of facility earnings. According to the head nurse, a reduction in the percentage of the HC revenue allocated to workers, along with the recent introduction of free maternity care, reduced monthly remuneration from approximately 100 USD to 40 USD, despite increased health service use. In addition, the head nurse reported that performance-based payments often arrived late, and drugs provided by the Work Bank did not cover needs. Health workers at both HCs expressed dissatisfaction with their payments, which informants claimed were insufficient to cover essential family needs, with the LPHC IT claiming that nurses earned at most 50 USD per month. Head nurses insisted that the government needed to pay decent and regular salaries for health workers to improve performance.

Regarding USAID IHP contributions to motivation, head nurses mentioned that USAID IHP had assisted through training on how to negotiate fixed consultation rates with community members, technical training to improve quality of care, and provision of subsidized drugs, all of which increased health service use. As indicated, the IT in the LPHA reported that the HC had not received medications from USAID IHP for more than a year and a half, and that USAID IHP was only supporting the HA through implementation of the Mashako Plan to increase child vaccinations.

Reference Hospital

Most of the 62 professional hospital workers relied on hospital revenue for remuneration, with only seven workers receiving salary and 13 workers receiving risk bonuses. The doctor noted that government salaries and risk bonuses were insignificant. Informants mentioned that the hospital was using the iHRIS software to monitor worker payments.

During the midline evaluation, 60 percent of hospital funds were allocated for health worker salaries, but with the start of the PBF project, the World Bank and DPS required that only 40 percent of revenue go to salaries, and that another 20 percent be used for capital investments, such as rehabilitation of the hospital structure. Therefore, although the PBF approach was increasing the use of services, informants claimed that remuneration was less than before the start of the partnership, thus increasing health worker dissatisfaction. Another change was that the local primes were divided into two, with 30 percent of salaries coming from hospital revenue and 70 percent based on performance-based indicators evaluated every three months. Both informants noted that hospital worker remuneration was very poor, affecting performance and propagating dissatisfaction, while at the same time workers were pushed to work harder to increase clientele.

Mentioned forms of motivation included training, which informants reported was essential to maintain skills. They said that they had not benefitted from USAID IHP training since 2021. Informants were unable to state ways that USAID IHP had contributed to health worker motivation. Hospital informants claimed that the only way to increase motivation and quality of care was for the government to pay regular salaries. The medical doctor felt that the hospital should provide other forms of motivation, such as free healthcare at higher-level facilities and health benefits for family members.

Perceptions of Health Workers and the Quality of Health Services

Women attending the FGDs were generally appreciative of the care provided by the facility health workers, especially in the LPHA where women acknowledged that the health providers worked hard despite challenging work conditions (e.g., poor infrastructure, insufficient space and equipment) and limited payment. Women from the HPHA expressed dissatisfaction with the reduction in drugs available at the HC, forcing them to spend money purchasing medications from local pharmacies. Responses highlighted concerns that the health workers were hoarding medications for their own use. Other complaints related to the cramped HC quarters.

Community Health Services

Infrastructure

Health Areas

Informants described community health activities as comprised of CACs, CODESA committee members, and RECOs, with CACs revitalized several months before the endline data collection. Informants mentioned that CACs, which were reported to be functional in all villages in both HAs, had become a central framework for community health activities and income generating initiatives. Comprised of RECOs, CACs nominate one RECO to represent the CODESA committee and to provide oversight of CAC activities. This was a major shift from the previous approach, whereby elected CODESA members did not necessarily represent all HA villages. CODESA member representatives formed key linkages between the community and the HC and were responsible for transmitting information on the focus of monthly messaging, which was supposed to be determined during the HA monthly monitoring meeting based on the analysis of HA indicators, back to their communities.

RECOs representing the CACs were responsible for recording the content of home visits, including the number of visits and messages transmitted, an approach they indicated was introduced by USAID IHP, compiling monthly activity data and transmitting monthly reports to the HC. Informants noted improvements in data collection related to community activities with assistance from USAID IHP. Informants from the HPHA also mentioned that the revitalization of CACs, which was supported by USAID IHP, had helped foment trust and collaboration between health providers and community members. He stated:

> *Before the project there was a climate of distrust between the service providers and members of the community. Some providers saw community members as annoying, like the police, but now there is a greater sense of collaboration and mutual cohesion has been established.*

Other organizations that reported participating in health activities included local associations, such as women's groups and civil societies, church groups, and local leaders, with the LPHA also working with private HCs.

Informants reported that community activities included awareness raising about health issues and associated prevention and treatment during household visits, community discussions, and announcements using megaphones to reach larger audiences, especially during outbreaks or to inform community members about upcoming events. During routine household visits, CHWs continued to assess the health of community members and identify and refer sick members to health facilities. Informants reported that focal health messages were also disseminated during church services, in school settings, and on the radio, with special events such as vaccinations or CPS also announced on the radio, although community radio did not reach the

LPHA. The HPHA informants underlined the importance of involving local leaders, who community members respect, in message dissemination. Hospital informants highlighted the important role that CHWs played in raising community awareness about key preventive messages, identifying and accompanying sick patients to the hospital, and participating in initiatives, such as identifying TB patients. However, the medical doctors mentioned that CHWs had become less dynamic due to the lack of motivation. According to all informants, RECOs and CODESA members generally supported the functioning of HCs by mobilizing community members to use health services and being present during CPN and CPS when they helped with the organization and dissemination of health messages during education sessions.

Other community activities reported included vaccination campaigns, bed net distribution, and screening for malnourished children. Informants reported that the frequency of mass vaccination campaigns varied according to the purpose, and that bed net distribution campaigns were organized approximately every three years, most recently held in 2022. There were no reports of mini-campaigns in either HA. None of the informants mentioned the existence of iCCM sites.

HC staff conducted monthly outreach for CPS consultations and vaccination services in different neighboring villages, with the IT from the LPHA claiming that it was sometimes hard to get RECOs to participate unless they were rewarded financially. Aside from outreach visits, health worker participation in community activities appeared minimal, primarily involving responses to uptakes in disease cases, and occasional participation in village sanitation and contraceptive distribution. The RECO informant from the LPHA reported that health workers did not visit HA villages.

The IT from the HPHA mentioned the existence of nutrition support groups, which provided education on food groups and essential dietary intake for pregnant women and young children, and counseling to caregivers of young children suffering from malnutrition. The LPHA RECOs had received some training on IYCF, but it was not clear whether the support groups were functional.

Promotional materials included flipcharts with illustrations and written captions kept at the HCs for CHWs to use during CPS and household visits, with ITs mentioning that use of illustrative materials helped caregivers better understand messages. Although they considered materials critical to the conveyance of messages, some CHWs reported that materials were old and falling apart. Because they were kept at the HCs, it was not clear to what extent the materials were used.

System Design

Role of CODESA Members

Informants reported that the CODESA was a health development committee whose members were RECOs representing CACs situated in HA villages. CODESA members served as a bridge between the HC and the community by providing health-related information to CACs and community members, and ensuring that CACs submitted regular activity reports. Informants reported that CODESA members were responsible for co-managing the HC by providing oversight on the use of HC supplies and reporting inappropriate health worker behavior to head nurses to ensure that HCs functioned in a way that was acceptable to community members. CODESA committees held monthly meetings to review ongoing CAC activities, and the CODESA President, along with other members, participated in monthly HA monitoring meetings with the head nurse and other health workers. CODESA members were responsible for compiling CAC reporting data and submitting a monthly report to the BCZS. They were also responsible for ensuring the development of CAC annual and quarterly health plans, as well as overseeing the execution of the plans. With the revitalization of CACs,

CODESA members were likewise responsible for carrying out their regular responsibilities as RECOs (see below), including participation in routine CAC meetings.

The HPHA CODESA member informant reported occasionally participating in monthly zonal meetings during which HAs presented performance data. In the HPHA, we were told that CODESA members were present during drug deliveries and involved in last mile distribution sponsored by USAID IHP. Reported training recently received was on community scorecards, FP, and nutrition, with USAID IHP leading community scorecard training. Informants reported that training offered by USAID IHP had sharply decreased since the midline evaluation.

In the HPHA, where there were 12 CODESA members; three members were women, including the president, whereas in the LPHA, three of the six members were female.

Role of RECOs

Informants reported that the main role of RECOs involved awareness raising carried out during household visits when they talked about health themes and when to seek facility care; identified sick patients and oriented those in need of care to health structures; promoted timely participation in CPS and CPN services; and screened for malnourished children. When sick community members declined to seek care, we were told that RECOs tried to convince family members about the importance of biomedical care, with the RECO in the HPHA mentioning that healthcare prices had been reduced and the RECO from the LPHA reminding sick patients that they could get treatment on credit. RECOs encouraged preventive practices, such as cleaning the compound, using bed nets, using potable water sources, and getting children vaccinated on time. RECOs were responsible for targeting anywhere from 15 to 25 households weekly, which was a reduction since the midline evaluation. RECOs also informed community members about special events, such as mass campaigns or outbreaks using a microphone, and that they helped in the execution of vaccination and bed net campaigns.

Informants from both HAs mentioned that there were minimal opportunities for RECOs to participate in training, with the only recent training offered by USAID IHIP on BCP. They added that when training occurred, few RECO participated. The RECO from the LPHA reported that he and other RECOs in his HA had never participated in training. When asked about training since the midline, the IT from this LPHA said:

> *Since 2021, some but not all RECOs have received training; there are RECOs who have not benefitted from training. Sometimes we ask for two out of 44 RECOs, and you feel even if there are debriefings [after the training] not all RECOs can benefit…I force them to report back to others about what they learned, and those who are briefed are used as people who have also been trained, they are considered active RECOs.*

The RECO informant from the LPHA mentioned that their roles had not evolved since the midline evaluation, adding that RECOs were not receiving new information and were getting less respect from facility health workers, stating:

> *The role of RECOs, it is not changing, RECOs are neglected. The job of RECO is starting to reduce its attraction, in our health area, we consider RECOs as I don't know who. For example, a RECO can enter the health center, but cannot request information on the health center. I had learned that a RECO has the right to information on the evolution of the health center.*

Informants suggested that most RECO learned from briefing sessions when other RECOs or ITs shared

information learned from a training. Interestingly, the IT from the LPHA mentioned that mentoring or counseling RECOs was not part of his work.

Informants from the LPHA reported 70 active RECOs, of whom about 50 were women, while in the HPHA, informants reported that 42 to 47 RECOs were active, with the majority women. Although both HAs had youth participants, informants agreed that youth, had a tendency to leave the village when income generating possibilities arose, and adding that youth found it illogical to work for free, and did not commit to work for long periods of time. In general, informants stressed high attrition linked to lack of motivation, requiring HAs to make ongoing replacements and making it difficult to specify how many RECOs were active. The IT from the HPHA said:

> *It is a problem; they don't understand why they get involved and why they decided to become community relays. It was only afterward that we realized that the faithful, active relays are only 42. They do not understand the definition of their role as RECOs.*

There was no mention of inappropriate behavior manifested by RECOs and CODESA members, who as intermediaries between the community and the HC, and community representatives were obligated to maintain good practices. One RECO mentioned that he sometimes advised patients on how to improve their behavior with health workers.

Focus group participants reported that RECOs disseminated similar messages as those shared by facility workers related to prevention of childhood illnesses, good nutrition, and the importance of using health facilities. Messages were shared during CPS visits, while circulating villages using a megaphone, and during household visits, giving credibility to the health worker messaging. Women from both HAs underscored increases in the acceptability of messages, with participants reporting signs of behavior change related to child vaccination, facility deliveries, ANC attendance, and the use of bed nets. Other mentioned venues where health information was disseminated, including churches and schools, with few women having access to a radio or telephone in both groups. Women living in the LPHA raved about the role that the RECOs played, suggesting that they circulate villages visiting households, propagate information, and screen for malnutrition, and that they also participated in vaccination and bed net campaigns. One woman said:

> *Our relays are the pride of the center and make it work, they do a remarkable job, there are some who go every day to the outskirts of the park, in the forest, they come back tired and deserve financial encouragement.*

Specific Services Offered

Bed Nets

Informants reported that bed nets were distributed when pregnant women first attended CPN at 16 weeks and during CPS when children received their final vaccination. The IT from the HPHA mentioned that USAID IHP initially refused to give bed nets to women who start after the 16th week of pregnancy, although they later relaxed directives on the approach. Another problem was that vaccine stockouts, especially BCG, made children who have completed all other vaccinations ineligible to receive a bed net, although informants reported that the MOH had recently changed the approach so that children who had not received the BCG vaccine due to common vaccine shortages could be given a bed net.

Mass campaigns occurred about every three years, with the most recent campaign in 2022. During campaigns, bed nets were distributed according to the number of people living in the households, with one informant

mentioning that enumerator calculations assumed that two to three people would sleep under one net. Informants indicated that mass distributions required lots of time and work, and that it was particularly difficult to reach people living in remote areas. Other challenges mentioned included that bed nets were insufficient to cover all residents, enumerators favored family members and friends, people may have been absent from their homes during distribution, and people used bed nets for other purposes, such as fencing in chicks and fishing, or bartered them in exchange for foodstuff. The medical doctor reported an uptake in malaria over the past couple of years, raising questions about the quality of the bed nets, including the duration of the insecticide and their appropriate use.

Women participating in FGDs mentioned that bed nets were distributed during ANC visits, when a young child received the first measles vaccination at nine months, and during general distributions, which they confirmed last occurred in 2022. Participants reported many problems, mainly related to the fact that the numbers of bed nets distributed did not meet family needs, and as a result, children often did not sleep under bed nets. Some reported that bed nets tore easily, and due to the infrequency of distribution, people had to go long periods without using bed nets. Some participants held misconceptions about malaria transmission, underlining the need for more awareness raising. Beliefs included that malaria was caused by breathing the smoke from brick manufacturing ovens, poor nutritional intake, working in swampy areas, and travel away from home.

Vaccinations

According to informants, vaccinations were provided routinely at least twice a week at the HCs during CPS sessions, and in targeted HA villages monthly during outreach visits. In addition, RECOs were periodically (approximately every quarter) requested to identify children who had missed vaccinations and bring them to the HC during CPS sessions. Mass campaigns also occurred during periods of epidemics, such as measles, to ensure that masses of children were protected. The IT from the LPHA reported that no children in the HA had zero vaccinations, and informants agreed that because of CHW awareness raising, fewer people were refusing to have their children vaccinated. Both HAs had solar run refrigerators with back up batteries, with informants reporting that their cold chains functioned well.

The most common problem reported by informants involved ongoing stockouts of BCG, which could last for several months, and even when stocked, were insufficient. Two informants mentioned that children could receive their final vaccination without having received the BCG vaccine, which they stated could interfere with their eligibility for a free bed net at the end of the vaccination calendar. Informants reported stockouts of other vaccines, notably diphtheria, tetanus, and pertussis, varicella,, and OPV, but for shorter time periods. One informant mentioned that caregivers became discouraged when vaccines were missing and skeptical about the work of the health workers, encouraging them to skip future visits and interfering with adherence to the vaccine calendar. In addition, ITs reported that their vaccine deliveries frequently did not correspond with requisitions.

Other challenges mentioned included vaccinating children in hard-to-reach areas, vaccine opposition by some religious groups, especially the Adventist Church, and concerns about side effects of vaccines, which caused caregivers to refuse vaccinations. The IT in the HPHA mentioned that CPS and vaccination services were hard to maintain because they require a lot of time and organization, but generate no financial return for the HC. The same IT mentioned that some health workers refused to participate in vaccination sessions or start sessions late in the morning when women needed to be home carrying out chores.

Focus group participants were aware of the vaccination schedule and knowledgeable that vaccines protect

children against illness. Although participants in both groups had young children who were generally up to date with vaccines, they acknowledged the existence of children in their communities who had not completed the vaccination calendar, with women in the LPHA mentioning that parents were sometimes reluctant due to concerns that vaccines caused fever. They agreed that fewer people were refusing vaccines than in the past, attributing the change to awareness raising and community recovery efforts led by RECOs. Interestingly, women from the LPHA contradicted information about the frequency of vaccination sessions, stating that vaccines were offered at the HC once monthly. However, they expressed appreciation for the availability of vaccines, with a mother from the LPHA stating:

> *Never in my childhood did I hear that children are scheduled to get vaccines. Currently, villagers know that the first Wednesday of the month is reserved for them. The vaccine is given every month, and the community, even the children know and wait for their day to benefit from the vaccinations offered in the health center. That is progress.*

Community Health Worker Motivation

CHWs agreed that they had accepted to work as volunteers, and that they had an obligation to villagers who elected them to fulfill their roles. They also recognized that facility health workers were poorly paid, noting that this helped them accept their work status. Some reported being rewarded by observing community members receive quality care, with the RECO from the HPHA stating:

> *My motivation is not money, but I feel proud when I send people to the health center. They tell me that if I had not made them aware they would have already died--they ask for the Lord to bless me, and I feel fulfilled. If after sending sick patients to the health center, they tell me that they were well treated, it makes me happy. The community entrusted me with the work I do in the community.*

However, they also noted that they were poor, had family members to feed, and deserved some compensation for their work, noting that compensation would push them to work harder. Health worker informants agreed that the lack of financial incentives negatively impacted community health activities, and compared with the midline data, reports of the lack of motivation were more frequent. The IT from the LPHA said:

> *Community health services face difficulties, CODESA members are volunteers, but they do not accept that. They tend to think that since they are called community relays that they will benefit from something from the health center. I have difficulty making the CODESA understand, some no longer work correctly due to complaints that they lack incentives, they tend to ask for motivation before they can work. Some of them agree to work and others do not, but the majority think that they should get something for participating in the activities.*

Health workers noted that community workers only received financial rewards when they participated in mass events or training, and that those opportunities involved few participants and were infrequent. The IT from the LPHA specified that CHWs were not satisfied with support from USAID IHP, stating that they had envisioned receiving more opportunities for compensation and material support. Head nurses emphasized the important role that community actors played in raising awareness about preventive practices and orienting sick patients to health structures. However, they noted that CHWs would be more effective if they

were motivated. The ITs noted that the regular turnover of RECOs, which signals work dissatisfaction, presented major challenges to the maintenance of quality community health activities.

VIVA Approach

Informants interviewed in HAs knew that VIVA was a newly introduced intervention designed to improve awareness raising related to MCH care, although some were unaware whether VIVA was functional in their HA. This contradicts information collected from DPS key informants, who indicated that VIVA had been scaled up in all 20 HAs in the Miti Murhesa HZ.

In the LPHA, three people had been trained on the VIVA approach, while in the HPHA, only one RECO had been trained. In both cases, those trained were responsible for briefing other HA RECOs on the approach. The IT in the LPHA reported challenges implementing VIVA because RECOs refused to work without compensation. None of the informants interviewed were able to describe the VIVA interventions (couple meetings, market quizzes, etc.) originally conceived by BA, nor did they mention that radio messages associated with the VIVA approach were being disseminated.

Kasai Oriental Province

USAID IHP provided support to 15 of the 19 HZs in Kasai Oriental, although some HZs were considered of higher priority. Moreover, for some programmatic areas, such as vaccinations, USAID IHP covered all 19 HZs. The European Union (EU) supported the remaining four zones. Since the midline, USAID IHP was providing less support to the Kasansa HZ, which was also supported by the EU and was included in our evaluation.

Objective 1: Strengthen Health Systems, Governance, and Leadership at Provincial, Health Zone, and Facility Levels in Target Health Zones

The USAID IHP representative considered strengthening institutional and individual capacity with a focus on leadership and governance, administration, and planning, as an essential piece of the USAID IHP mandate. Key informants reported that USAID IHP provided financial support to DPS and BCZS offices to develop annual operational action plans, detailed workplans, and budgets, with USAID IHP offering technical support to prioritize problems, formulate approaches to address the problems, establish objectives, and design a results framework. Key informants mentioned that the USAID IHP approach emphasized that annual plans must be guided by real evidence and needs, provided by the PICAL assessment. Although the USAID IHP representative suggested that the assistance with planning had equipped government officials with essential skills, the MCZs believed that they already possessed adequate technical skills to develop action plans independently,

Key informants considered PICAL as a valuable tool to analyze and diagnose current problems in the DPS and BCZ institutions that needed to be addressed. In Kasai Oriental, the third PICAL exercise had occurred just before our evaluation, but only in a few HZs and not including the HZs covered in our evaluation. Health professionals at the DPS and BCZS levels noted that that primary healthcare training, which USAID IHP had supported before the midline evaluation, had included valuable training on planning. However, key informants mentioned that ineffective leadership and lack of proactive decision making continued to undermine timely execution and health activities. MCZs noted that USAID IHP had decreased support since the midline evaluation during the budgetary constraints, noting that almost no capacity building training had been carried out since 2022. The MCZ in the HPHZ mentioned the need for financial and administrative management training. MCZs underlined the important support that USAID IHP had provided related to

supervision, particularly related to “clinical” coaching, although the MCZ from the LPHZ noted that recent reductions in visits had negatively impacted the quality of healthcare.

Support related to good governance focused on strengthening the capacity of health officials to follow government norms and directives related to the management of finances, human resources, equipment and supplies, and sick patients. As part of the approach, USAID IHP provided office equipment and financial support to the IPS, which oversaw health inspection and control, to carry out quarterly audits to assess whether health structures conformed with standards related to good governance. As part of the approach, USAID IHP financed the implementation of a free telephone line, referred to as a greenline, to denounce fraud, abuse, and poor-quality healthcare. Calls made on the fraud and abuse accountability greenline were received and assessed by IPS officials, who scheduled follow-up audits based on the authenticity and severity of the accusation. The evaluation team learned of several instances involving reports of stolen materials through the hotline, which the IPS had investigated, leading to disciplinary actions. The team also learned that two MCZ, who had recently been charged with flagrant offences, and who had been investigated, judged, and suspended for their crimes, were acquitted by provincial government officials shortly after having been convicted. At the time of the endline evaluation, both doctors once again filled the role of MCZ in a HZ. When the evaluation team informed the USAID IHP representative that the sanctions had been lifted, he was astounded, stating:

> *But why did the sanctions not last, that's what I'm asking. The political weight, the political weight of the big system, politics weighs a lot, the system must be depoliticized…. this is the problem, they do not learn, they do not appropriate. USAID IHP cannot manage the system, we can only provide support, if the MCZ steals they must follow the rules.*

Only the LPHZ had a greenline provided by USAID IHP, which was installed in 2022, with the HZ representative reporting that the number was given to all RECOs to report negative practices. The same MCZ mentioned that IPS officials visited the HZ periodically to inspect the management of drugs, equipment, and personnel, adding that these visits helped reduce negative practices. However, the DPS representative considered the support provided to the IPS as insufficient to respond in a timely fashion and to address all needs. Government key informants were skeptical whether the greenline would be continued after discontinuation of USAID IHP support. Key informants also mentioned that the telephone payment system used by USAID IHP, since 2022 to pay health workers for their participation in program activities, has helped improve that payments were made appropriately.

Key informants reported that USAID IHP provided health structures with a packet of subsidized essential medications for treatment related to MCH, malaria, and TB, which was designed to complement assistance provided by other IPs. Medications were delivered by Chemonics International from the CDR to the HZ, with USAID IHP supporting the last mile delivery to heath structures. Government informants reported that the quantity of medications delivered often failed to respond to requisitions and meet facility needs, especially for specialized drugs for TB or malaria treatment. In addition, deliveries did not follow the quarterly schedule, and sometimes included medications that were close to expiration, leading to stockouts and forcing structures to purchase drugs of lower quality. One MCZ attributed stockouts to the late submission and errors in drug requisitions, as well as irregular drug deliveries. One MCZ suggested the need for more training on developing drug requisitions, adding that USAID IHP had already provided some training on management of

drug supplies. The same MCZ mentioned that stockouts encouraged villages to seek care in informal settings. Informants reported that USAID also supported quarterly meetings in the DPS to assess drug management, and supervision to monitor drug management and quality. The DPS representative reported that they were not using the InfoMED software to track equipment and drug supplies, although the MCZs were using the software to track drug supplies that they considered helpful to determine when stockouts might occur.

Informants mentioned that in late 2022 through early 2023, USAID IHP provided a wide range of essential equipment to HCs and hospitals. The MCZs suggested that the equipment had had a tremendous impact on facility operations and quality of care, expressing gratitude to USAID IHP. Examples of equipment received included beds and mattresses, maternity beds, ultrasound machines, operating tables, surgical lamps, oxygen concentrators for children and adults, resuscitation materials, autoclaves to sterilize materials, as well as smaller equipment such as forceps, thermometers, and scissors. One MCZ mentioned that the equipment was delivered directly to the health structures, and that supervisory visits were subsequently made to assess the maintenance and use of the equipment. Office equipment was provided to the BCZS, including printers, chairs, and other smaller necessities, as were solar batteries. On an ongoing basis, USAID IHP supplied consumable office supplies to the HPHZ.

USAID IHP provided financial and technical support so that the DPS could receive quality data to guide strategic decision making, with one MCZ noting that due to USAID IHP assistance, the HZ office had the capacity to collect, transmit, analyze, and interpret data. The package of assistance included computers; credit for Internet connection; data collection instruments (the MCZs mentioned that tools were insufficient); training on data collection, analysis and evidence-based decision making; and support for monthly data monitoring meetings at the HZ level and quarterly meetings at the DPS level to analyze and validate data. USAID also supported audits to assess data quality at the HZ level and central level where the DHIS2 was controlled. Government informants reported major improvements in data completeness and timeliness of submission, except for distant HAs that faced challenges transmitting the data. However, informants reported ongoing challenges with missing data, which they attributed to inadequate data collection tools, and data cohesion and precision, although they noted that progress was being made. Informants shared the future goal of equipping HA personnel so that they could enter data directly, which would address some of the data quality issues that occurred at the grassroots level.

There was general agreement that community health activities played a critical role in strengthening the health system, with key informants reporting an improvement in community activities since the midline evaluation. Informants underlined the important assistance that USAID IHP offered through the revival of CACs, which provided a community framework for CODESA committees and RECOs to execute activities, collect data, and compile monthly health reports. Aside from CACs, MCZs reported little collaboration with other community-based organizations , although this had been part of the USAID IHP's original approach. Informants indicated that USAID IHP provided monthly payments for all HZ CODESA meetings and for some CODESAs to participate in monthly zonal monitoring meetings. According to the USAID IHP representative, USAID IHP supported the community scorecard initiative in 317 HCs, although it had not been supported by USAID IHP in either of the HZs evaluated during the endline. The USAID IHP representative also reported sponsoring mini-campaigns, especially related to the recovery of unvaccinated children. According to informants, the two HZs in the endline evaluation had established more than 20 iCCM sites with support from USAID IHP, and the RECOs managing the iCCM sites were receiving 10 USD for transport costs to the HC to

restock drugs. MCZs mentioned that it was hard to maintain female RECOs due to the heavy work demands of women in the province, adding that female RECOs generally did not maintain positions of authority. Informants reported high RECO attrition due to the lack of motivation, requiring that RECOs be replaced regularly and impacting CAC operations.

The USAID IHP representative reported training health personnel on a range of health themes, and that USAID IHP supported the use of the iHRIS platform to monitor personnel; however, the MCZs did not use the iHRIS platform and continued to maintain lists of active health personnel. Informants reported that A3 workers had become rare partly due to the IPS enforcement of government standards. Government informants cited many problems with staff recruitment, claiming that many DPS and HZ workers were recruited for political reasons and were unqualified, undermining the advancement of the health system, and that there was an excess of both DPS and BCZS staff. For example, although the DPS was supposed to have 12 regular staff, they had 20, many of whom were appointed by government officials at the central level. He stated:

> *As long as the law is not respected, nothing will advance. We must respect the law, but who must enforce this law? It's the politicians. The administrative head doesn't show leadership, it's complicated… Unfortunately, many HZ cannot function independently because we put people who shouldn't be there, reducing their capacity. If we had respected the advancement process, someone at the lower level who had developed certain skills would be moving up.*

MCZs also reported that the DPS recruited staff for HZ posts who were unqualified, and that the recruitment of health facility staff failed to comply with government norms. The MCZ from the HPHZ said:

> *You have someone who comes with a document from the DPS saying that he was assigned to the BCZS office as a supervisor. And the next day, someone else can come. There may be ten to fifteen of them. What are you going to say? It was the DPS who recruited them. There is no need, but the person is there. What are you going to say? Refuse your boss' signature? You have staff who have no work to do, but they are your agents. You must create work, so that they feel busy and figure out how they will be motivated. We must think about all of this daily.*

The MCZ informant in the HPHZ mentioned that 22 percent of health workers in the province received government bonuses, whereas 4 percent were paid monthly salaries, although payment rates were reported to be higher by the MCZ in the rural HZ. Key informants indicated that bonus payments for doctors were about one million CF (400 USD), but were paid irregularly, and salaries were approximately 300,000 CF (120 USD) for doctors and 18,000 CF (7.20 USD) for nurses.

Key informants reported that USAID IHP supported a wide range of meetings and working groups at the DPS, HZ, HA, and community levels critical to ensuring good coordination with key partners and stakeholders and avoiding duplication of efforts. USAID IHP had supported regular meetings at the DPS level with key government partners and other IPs, and at the HZ level, meetings financed administrative council, management committee (COGE), monitoring, and CODESA committee meetings, with the USAID IHP informant mentioning that the biggest challenge was ensuring that all partners participated. Although the unique contract was considered a good mechanism to ensure coordination with partners, at the time of our evaluation, the yearly agreement had not yet been signed.

As part of the supplementary Ukraine funds, USAID IHP supported supervision carried out by the *Programme National de Nutrition* (National Nutrition Program) and meetings of a multisectoral committee dedicated to the prevention of malnutrition. Four HAs in four HZs in Kasai Oriental received support to improve food security, with proposed activities involving training on agricultural techniques, culinary demonstrations using local foods, and raising of small domestic animals. Due to a late start in seed distribution, which was in part due to challenges identifying seed producers that met USAID standards, those trained in improved agricultural techniques had already missed two planting seasons. We were also told that small domestic animals had not been distributed, and in general, few activities were underway.

Objective 2: Increase Access to Quality, Integrated Health Services in Target Health Zones

Malaria

Before the midline evaluation, USAID IHP trained at least two health personnel per structure in all HZs on malaria treatment and prevention. Trained health workers were requested to brief other health providers in their respective facilities on knowledge acquired during the training, and USAID IHP carried out post training monitoring at health structures to correct problems. A separate training was held for laboratory technicians on malaria diagnostics. Since the midline evaluation, there had been more emphasis on supervision to ensure quality treatment. Specifically, USAID IHP supported supervision by DPS representatives of the malaria program to assess case management using the Health Network Quality Information System tool and coached health workers, as well as routine BCZS supervisory visits. The USAID IHP representative mentioned that there was a period in 2022 when supervision was curtailed, and since then, USAID IHP support for supervision visits had been reduced to one routine supervision visit per quarter. He added that USAID IHP provided motorcycles so that government officials could maintain routine supervisory visits as mandated by the government official strategy. He also mentioned that USAID IHP altered support for BCZS operational costs, providing support every three months rather than monthly.

USAID IHP supported the availability of malaria treatment medications to the CDRs, including ACT-based pills and injectables, and prophylaxis for distribution to pregnant women during ANC visits, and ensured the distribution of insecticide-treated bed nets to HZs. With malaria program funds, USAID IHP also provided support for “last mile” transport of drugs to the HCs, and to the iCCM sites where children up to 13 years of age were treated for free. The MCZ from the LPHZ reported the receipt of lifesaving equipment, such as oxygen concentrators for malaria cases, as well as training on how to use the equipment. The malaria program also financed the production and distribution of treatment registers and data recording and entry tools across HZs, which were produced in Kinshasa due to USAID regulations, although the representative admitted that USAID IHP was unable to keep up with the needs and have been trying to produce treatment tools locally. USAID IHP also supported malaria program coordination meetings at the provincial level (although the USAID IHP presence had been reduced), and monitoring meetings in HZs, with a day dedicated to malaria. The DPS representative also mentioned that USAID IHP sponsored working meetings examining a range of illnesses, including malaria, although the support had been reduced. In addition, USAID IHP financed malaria international days, mini-campaigns focused on malaria, and preventive messaging through the VIVA approach. The USAID IHP representative reported that in fiscal year 2023, the incidence of malaria cases, including severe cases, had decreased, as had malaria related deaths, noting that severe cases were better able to get to hospitals for blood transfusions and that malaria diagnostics had improved. A challenge

reported was staff turnover, the fact that trained health workers failed to share information acquired with other health workers, and the lack of ownership of malaria activities by government workers.

Maternal and Child Health

USAID IHP offered a package of activities in 10 HZs, with a focus on capacity strengthening. Before the midline evaluation, USAID IHP led training on BEmONC at the HC level, and CEmONC at the hospital level, during which training was offered on C-sections and safe ways to administer anesthesia, with subsequent supervision and coaching of trained workers. More recently, USAID IHP supported the training of doctors to lead clinical coaching quarterly and helped set up sites (six HZ sites with two doctors at each site) where practical training using mannequins on delivery and post-delivery assistance and insertion of long-acting FP methods, such as implants and IUDs, was offered. In addition, USAID IHP provided extensive equipment to maternities, including delivery beds, ultrasounds, and resuscitation equipment, as well as smaller materials, to five HCs in 10 HZs. Training on more sophisticated equipment was led by World Health Organization (WHO) experts who trained local health workers as trainers of trainers. Additional training was led by DPS staff and local university faculty on less advanced materials. However, the endline evaluation team found that some equipment was not being used due to lack of electricity, inadequate light, limited space in the maternity, and health personnel were unfamiliar with the equipment. The USAID IHP representative said:

> *The are infrastructure challenges, you bring good materials, good maternity beds but there is not enough space in the structure. It is dark, that is the first challenge, another challenge is that we need to increase the number of people trained on the equipment. That is very necessary.*

USAID IHP also provided training and financed support to committees comprised of representatives from different sectors at the provincial and HZ levels to audit maternal deaths; however, due to decreased support, some committees were not functioning at the time of the endline evaluation. Starting in 2022, USAID distributed lifesaving drugs, including oxytocin and magnesium for complicated deliveries. USAID IHP also contributed to meetings carried out by the reproductive health committee and provided tools, such as flowcharts and partograms. USAID IHP also helped establish hygiene committees in hospital settings and set up safe disposal of biomedical waster. Regarding community activities, CHWs promoted attendance at both ANC and CPON.

Although informants underscored the continued need for clinical obstetric training, an ongoing challenge related to the transfer of trained doctors and the cost of maintaining the clinical training sites. The USAID IHP representative said that they were working with other IPs to see how to make the clinical training approach sustainable.

Nutrition

Assistance focused on reviving and supporting nutrition IYCF groups, which included training of CHWs on culinary demonstrations in four HZs. USAID IHP also set up surveillance committees to oversee IYCF sentinel sites, ensured that growth monitoring and nutrition education sessions were included in CPS sessions, strengthened the identification and referral of malnourished children visiting iCCM sites, and raised community awareness about good nutrition in HZs where other IPs were not carrying out community activities. Informants reported high rates of malnutrition, and insufficient prevention and treatment support, with zonal-level informants mentioning ongoing stockouts of treatment supplies for malnourished children in

HC and hospital settings.

Family Planning

USAID IHP supported 10 HZs to offer a range of contraceptive methods so that clients were free to choose what was best for their situation. The approach involved training of facility health workers on FP methods, and referrals to other facilities when they were unable to provide or administer the preferred method. In addition, pharmacists were supplied with contraceptives and trained in FP counseling and the administration of methods, although it was not clear how extensive this approach was. At the community level, USAID IHP supported the *distributeur de base communautaire* (community-based distributors of contraceptives) approach, whereby RECOs were trained to raise awareness about FP during household visits and CAC meetings, and were responsible for distributing oral methods and referring women to facilities for methods requiring a medical intervention. More recently, USAID IHP involved third-year nursing students who were qualified to give injectables in community-based contraceptive distribution activities. Informants agreed that the uptake of FP was slow, which they attributed to concerns about side effects and the tradition of having large families. More recently, awareness raising had become more focused on promoting FP to reduce maternal death.

Tuberculosis

Informants reported that activities related to TB involved screening for cases, which could include mini-campaigns, especially in areas where a case had been identified; provision of treatment drugs; and clinical follow-up of cases to ensure drug compliance and the patient's condition. When cases were detected, the program provided the patient with drugs for six months; however, informants reported delays in treatment, which is particularly dangerous in resistant cases, and challenges isolating resistant cases. USAID IHP provided assistance to hospital laboratories to assess samples, although in one of the evaluation's HZs, hospitals lacked essential materials to carry out the laboratory work.

Immunization

USAID IHP supported the transport of vaccines and supplies needed to administer vaccines. Informants reported that USAID IHP assisted with training on how to maintain the cold chain, including maintenance of solar panels. In addition, USAID IHP supported the Mashako Plan involving the recovery of children who missed vaccinations. Informants reported severe problems with stockouts lasting up to five months for the BCG vaccine, and to a lesser extent with the OPVvaccine, which were both supplied from the central-level MOH. They mentioned that since the government had become more involved in supplying vaccines, more stockouts had occurred. Informants reported many cases of children with zero doses and that the province had a low rate of fully vaccinated children.

Quality Assurance

According to the USAID IHP representative, quality assurance to assess integrated quality of care had not been done by USAID IHP as originally planned. Informants reported that USAID IHP focused on data quality, involving support of quarterly supervisory visits of 15 HZs to provide coaching as needed, and technical support provided by three USAID IHP technicians who worked with the DPS. As part of this effort, USAID IHP also supported DPS quarterly data validation reviews, as well as monthly data monitoring and validation meetings at the zonal level. The DPS key informant mentioned that efforts to maintain data quality would be difficult to sustain without IP assistance.

Referral Systems

The DPS representative reported many deficiencies with the referral system, indicating that health workers disregarded government rules related to treatment so that they could keep sick patients at HCs and generate revenue. The same key informant mentioned that community members had misunderstandings about hospital care, causing them to refuse referrals. He stated:

> *The system suffers a lot, particularly young health workers prefer to try everything they can to keep patients in the health center even if it is clearly a referral case. For example, severe malaria should not be treated in health centers, but you will find that young practitioners will do anything to treat, they will obtain products and give drugs intravenously all for money. So, there are problems on the facility side, but also on the community side where people refuse to be transferred. They say that I must die here. Lots of community members are really scared, they'll tell you the hospital will ask for money, but we don't have any. They consider the hospital a foreign environment. Very few people understand that referral is a treatment. We don't refer because we don't understand the care, but perhaps because the hospital uses a technique that is not applied in the facility. Materials used for an exam may not be in the facility. But when we refer, they say, 'No, no, no, do what you can do, let it end here.'*

Innovative Financial Approaches

Key informants were unable to identify any innovative financial approaches introduced by USAID IHP. The DPS representative mentioned that flat rate pricing was only being implemented in the four HZs funded by the EU, and that health mutuals introduced by other organizations had shown little uptake.

Objective 3: Increase the Adoption of Healthy Behaviors, including the Use of Health Services in Target Health Zones

When asked about activities related to behavior change, key informants focused on the VIVA campaign, which was initially piloted in two HZs in Kasai Oriental. At the time of the endline evaluation, VIVA had been fully scaled up in nine HZs and partially scaled up, meaning that only HZ personnel had been trained, in two HZs. Key informants described VIVA as an innovative, community-based approach comprised of four interventions used to disseminate behavior change messages related to essential family household practices and the use of health services. The USAID IHP representative stated that VIVA messaging focused on lower-performing health indicators, adding that VIVA interventions had become a key element in the package of routine community activities carried out by RECOs. Informants indicated that at the time of the endline evaluation, BA was providing technical assistance, support for the conduct of meetings, supervisory visits, and ongoing assessments of the campaign, while USAID IHP was working with government actors on the scale-up of interventions and appropriation of VIVA implementation. Although there was some mention of the VIVA mass media approach, few details were provided. USAID IHP and DPS key informants reported that the quality of the community interventions had decreased since scale-up, with the DPS official claiming that VIVA interventions were no longer functioning in the province. The USAID IHP representative attributed the decrease in quality to the instability of both facility and community actors, whereas the DPS official linked the downturn to the removal of gifts that had been used to motivate participation. She added that the provision and subsequent withdrawal of gifts had increased challenges related to RECO motivation and community participation in all community activities, noting that partners needed to consider the potential consequences of approaches before they were implemented. Informants reported that VIVA had been scaled up in full in the

HPHZ and partially in the LPHZ; however, only the key informant from the HPHZ was familiar with the approach, which she claimed was impacting positively on HZ indicators. According to informants, data collected through VIVA activities were being entered in the DHIS2.

Key informants reported that mini-campaigns had been a primary USAID IHP activity, with the USAID IHP representative indicating that more than 100 mini-campaigns were held in 2023. Campaigns were organized in HAs experiencing a health problem (e.g., increase in malaria or TB cases) or a dip in health indicators (e.g., ANC attendance, children vaccine coverage), and were designed to raise awareness, encourage behavior change, and increase the use of health services. There was general agreement that mini-campaigns boosted targeted health indictors, but questions were raised regarding sustainability. In addition, USAID IHP periodically sponsored other community efforts, such as the identification of children who had missed vaccinations or women who missed ANC visits who were referred to HCs for services. Government officials at the DPS and HZ levels reported that no mini-campaigns had been planned for 2024.

Other USAID IHP-assisted community activities mentioned included international days in HZs where a health problem existed, training of RECOs on different health themes, the conduct of listening clubs in 19 HZs, and support of nutrition groups propagating messages on the prevention of malnutrition, conducting culinary demonstrations, and screening for malnourished children in 19 HZs. The key informant from the LPHZ mentioned that USAID IHP funded WASH activities involving community hygiene and the construction of boreholes in four HAs before 2022. The USAID IHP representative also reported assistance related to food security funded through the Ukraine supplementary funds involving improved agricultural practices, food transformation and domestic animal raising in four HZs, although the evaluation team found that little progress had been made. He also mentioned that USAID IHP had supported the establishment of gender units at the DPS and HZ levels and improved interpersonal communication among health workers.

Informants noted that CACs and CODESA committees had been revived over the past few years in many HZs. Recent revival efforts were carried out in 2024 in the Bipemba HZ (but not Kasansa) with the start of the community scorecard approach, which USAID IHP started to introduce in focal HZs in 2024.

Key informants agreed that the establishment of CACs had helped engage community members in HA activities and improved the organization of the work of RECOs, who were elected and responsible for following 30 households each month, and CODESA committees. However, the DPS representative reported that CAC and CODESA committee revival was funded by UNICEF, which provided 30,000 USD for revitalization efforts in four HZs each year. Some informants reported that RECOs were starting to refuse to work on a volunteer basis and were abandoning the work in large numbers. The DPS representative mentioned that a new approach was to only allow working people to be elected as RECOs, but it was not clear how this would function in a context where the vast majority of citizens were unemployed. The USAID IHP informant claimed that most community activities were done in conjunction with the government and did not require outside assistance, apart from mini-campaigns, and would be sustained once USAID IHP support was discontinued.

Other Observations

The USAID IHP representative considered the lack of government appropriation of routine activities, such as supervision or data monitoring, by DPS and BCZS health professional workers as the biggest challenge. He stated that for more than two years, USAID IHP had been working to delegate responsibilities to the DPS and to build the sustainability of activities, but progress was slow, adding that the government needed to start

contributing to operational funds to ensure that activities functioned in the future. When talking about health personnel, the informant described an unwillingness to take ownership of their work and limited accountability, also adding that government corruption continued to be pervasive. He considered the involvement of central-level officials, who he stated often lacked an understanding of the provincial context and needs, as an ineffective, costly approach. The same informant underscored the negative impact of political influence, explaining that health workers who had connections to people with political power ignored directives from the MCZ and government norms, undermining the health system. He stated:

> *We realize that the big system weighs heavily on the DPS, it weighs heavily on the health zones, political figures affect people in the morning and evening. Without prior need expressed by the DPS and the health zones, people parachute in, and people use their connections to bypass their immediate supervisors. This kills the institutions. You even have ITs, chief doctors of the health zones, who have people who protect them, and they do not report to the division head, nor does the IT report to the zonal head doctor because of who he knows, this kills the system.*

Reported problems related to health personnel included that they were never in their work place and were often in conflict with one another.

USAID IHP informants also mentioned that the DPS often had different notions of the USAID IHP mandate, with one informant suggesting that some government workers resisted the USAID IHP approach and wanted the program to fail. They provided examples of government workers overtly defying USAID IHP- funded activities, such as sending the wrong people for training or claiming to carry out supervisory visits when health workers were in other locations. It was also mentioned that the MCZ and other officials often failed to disseminate important information related to USAID IHP activities to other health workers, with some suggesting that this was intentional.

On the government side, informants questioned the excessive costs involved in setting up USAID IHP offices and sub-contracts with national organizations, stating that the program had established a parallel DPS system. One high official stated that the current approach focused on providing technical assistance and payment based on deliverables showed little impact and results. Another mentioned problems related to the USAID calendar year, which did not coincide with the government's year. The DPS representative reported that the spending freeze, which took effect in 2022, seriously impacted activities, stating:

> *The big challenge was, it was even a danger for us, when there was a freeze on activities, and after that the budget experienced a big reduction. There has been a general decline in support to the point that the activities are not carried out as before, you feel certain restrictions.*

Successes reported by government officials included improvements in data quality (although data consistency was mentioned as a persistent problem), as well as community activities related to illness prevention. The DPS representative said:

> *The big challenge now, the big challenge at least from our side, is the data quality. There are many things that are done to improve data quality, but getting there is a real journey and there is still a lot to do. Because when you follow the entire chain, starting from the production of data, there should be quality data. But the one who produces the*

data does nothing with it. We don't know how the people producing the data manage and analyze it. How do they do their analysis? So, we find that there is a lot of data that is inconsistent, aberrant, or biased, and we are really struggling to improve the quality. To work well, we need real health information. You see, that is the problem. This is where we have difficulties. So, the big challenge we have now is to get quality data. Improve the quality of health information. If we can improve the quality of the data, we will have made a big step.

Government workers appreciated that USAID IHP provided data collection tools, although they mentioned that the speed of distribution had decreased, and that structures were complaining that the tools were insufficient. One MCZ lamented that there was a tendency to criticize personnel and disregard successes, with little effort to provide positive reinforcement to health workers.

Kasai Oriental Province: Bipemba Health Zone

Background Information

Data collection was carried out between late April and early May 2024 in Bipemba, an urban HZ that has 19 HAs. Bipemba is in Mbuji-Mayi, the capital city of the Kasai Oriental province and headquarters of the provincial government's offices, including the DPS, which has been operating in the province for decades. However, in 2015, the province of Kasai Oriental referred to in this report was divided into three separate provinces, including Kasai Oriental, Sankuru, and Lomami, under the DRC's reorganization into 26 provinces.

This evaluation was conducted in the same HPHA and LPHA included in the midline evaluation, which were selected according to child health indicators, such as service use at HCs for major child diseases and vaccinations. In each HA, the evaluation team conducted in-depth interviews with the IT, one CODESA member, and one RECO, as well as a RECO in charge of an iCCM site in the LPHC. We also administered in-depth interviews with an administrator and clinician from the Reference Hospital. Last, we evaluated the infrastructure of all HC and hospital facilities.

The mean age of our informants was 49 years, and most of them (5 of 8) were men. The ITs, CODESA members, and RECOs had an average of 13 years of schooling, whereas the primary care physician had completed 18 years of training. The informants had ten years of work experience in the same position, on average. No informants reported simultaneously holding other occupations. On average, informant households included ten members.

Focus group participants included mother and grandmother caregivers of young children.

Facility-Based Services

Infrastructure

Health Centers

The HPHA, which is in peri-urban neighborhoods on the outskirts of Mbuji-Mayi, had eight CACs, which represented an increase from the five CACs found during the midline evaluation. The HA did not have other health facilities or functioning iCCM sites. The HC was a private facility located 5.5 kilometers from the HGR, which worked in partnership with the HZ. The building was constructed in 2002 and most recently renovated in July 2021. The HC was comprised of two buildings, which included a pharmacy, a functional laboratory with a microscope, separate rooms for treatment consultations and overnight observations, and a maternity. The facility did not have improved sanitation facilities or running water (although separate toilets were available

for men and women), or a functional incinerator. Solar panels provided electricity 24 hours a day, and water had to be purchased. Treatment and other service fees were not posted.

The LPHA included nine CACs located either in peri-urban neighborhoods or villages outside the city. This HA had four other private health facilities and one iCCM site, and was eight kilometers from the HGR. Located in a peri-urban neighborhood on the outskirts of Mbuji-Mayi, the HC was built in 2020 of adobe bricks provided by residents and the ceiling and dirt floor were unfinished. The facility had a laboratory but did not have an incinerator or improved sanitation facilities, with men and women sharing bathrooms. The HC used solar panels received from USAID IHP, which provided electricity for lights and to run the refrigerator. The HC had a water tank to collect rainwater but ran out of water during the dry season. Consultation fees were not posted, with fees established on a case-by-case basis. Since the midline evaluation, community members raised enough money to purchase the land where the HC was located.

Reference Hospital

Comprised of different buildings, including a pediatric ward, the Reference Hospital was built in 1968. Since the midline evaluation, the hospital had used local revenue to initiate renovations on all buildings, which were underway during the endline evaluation. The hospital administrator explained that the roof had collapsed in several of the hospital buildings and renovations were urgent. To make the interior more appealing to patients, the hospital was also painting the interior, installing lights, and posting signs in the interior.

The hospital had a functioning incinerator, although it did not meet safety standards. There was no running water, with the facility relying on cisterns and wells for water. The HGR had solar panels and also used a generator when needed, although the energy did not provide enough power to operate some essential medical equipment, such as autoclaves.

Services Offered

Health Centers

HCs provided an integrated package of minimum services, including treatment consultations, minor surgery, a laboratory with technicians, delivery care with trained midwives, testing and treatment for TB and HIV, as well as promotional services, including ANC, CPON, and CPS consultations, vaccinations, and FP. Although both HCs were supposed to offer treatment for malnourished children, neither had the appropriate supplies. The ITs stated that the HCs offered fixed CPS consultations at least twice weekly, as well as outreach visits where CPS was offered in distant locations. It is important to note that our data collection coincided on the day of a scheduled CPS session in the LPHC, but the session was not held. Both ITs reported that USAID IHP had supported the revitalization of CPS sessions, which included growth monitoring, screening for malnutrition, vaccinations for children up to 15 months, distribution of vitamin A and deworming medication, and counselling on prevention of childhood illnesses and malnutrition, as well as bed net distribution when children got their first measles vaccine at nine months of age. The IT from the LPHC reported recent increases in CPS attendance, although he added that it was difficult to convince mothers to attend CPS beyond the child's first birthday.

The HPHC IT reported that USAID IHP provided facility registers and consultation forms, although throughout 2023 and up to the beginning of 2024, no consultation forms were provided, and the treatment registers were inadequate. Although the IT from the HPHA expressed frustration about the failure of USAID IHP to distribute adequate forms and registers, she said:

> *I saw yesterday, they brought me some consultation forms. I can say that it's something. When you have nothing, even when they give you a little bit, it is something… the few registers we were given saves us from buying them in the market.*

Neither HC received supervisory visits to assess integrated quality care, although ITs indicated that health personnel carried out routine and program-specific supervisory visits.

The ITs reported that health workers adhered to norms outlined in national guidelines by following treatment flowcharts provided by USAID IHP in 2021 to diagnose illnesses and make decisions about treatment. Health workers considered flowcharts invaluable to quality care, with the HPHA IT referring to flowcharts as their "bible," adding that it helped workers determine whether a patient should be treated at the HC or referred to a higher-level facility. Head nurses reported integrating preventive messages during treatment consultations of young children according to the child's condition and history, such as the importance of vaccinations, using bed nets, and nutritional intake.

Focus group participants reported that they frequent the HCs to get treatment for a range of illnesses affecting young children, such as fever, malaria, diarrhea, typhoid, skinlesions, or malnutrition. However, women in both groups agreed that they only visited the facility after observing that less expensive medications, which they obtained from local pharmacies, were not reversing the condition. Women also mentioned attending ANC visits at which they received counselling on good nutrition, the importance of using a bed net, childhood vaccinations, and CPS consultations, which included growth monitoring, and distribution of vitamin A and mebendazole. Women from the HPHA added that during treatment consultations, nurses provided information on the importance of exclusive breastfeeding, prevention of childhood illnesses, including malaria, childhood vaccinations, FP, and hygiene and sanitation. Women in the HPHA appreciated the care provided by health workers, who they described as welcoming and cordial with patients.

Reference Hospital

The hospital had services for internal medicine, obstetrics and gynecology, pediatrics and neonatology, surgery, diagnostics, including a laboratory and imaging (e.g., radiology, ultrasound), treatment for severely malnourished children involving the administration of therapeutic F75 and F100 milk, and HIV and TB screening and treatment, with an area dedicated to TB treatment for children. Informants stated that clinicians followed treatment protocols established in 2017 by provincial and national authorities, and which were renewed in 2023 to integrate treatment and preventive care. Informants highlighted the impact that treatment protocols had had on quality of care, with protocols for pervasive child diseases—including malaria, acute respiratory infections, and diarrhea—reported to increase recovery rates. A HC situated next to the hospital provided a package of promotional and preventive services, including ANC, CPS, and child vaccinations.

Equipment

Both HCs had basic equipment, including thermometers, stethoscopes, tensiometers, sterilization supplies, as well as microscopes. HCs had a scale for newborns and babies, as well as salter scales and height measures, although neither had a functioning adult scale. Both HCs had adequate beds and mattresses for sick patients under observation and in the maternity ward, and each HC had recently received new solar run refrigerators. Regarding hygiene, HCs had several handwashing stations. The HPHA displayed posters on the walls featuring messages on TB, FP, and vaccinations, whereas the LPHC did not have such posters.

Only the LPHA, a state-run HC, received equipment from USAID IHP at the end of 2023, which included sick patient beds, delivery beds, microscopes, blood pressure monitors, stethoscopes, consultation tables, portable room dividers, a microscope, a baby balance, different types of forceps, and drums used to sterilize instruments. The LPHC IT mentioned that community members appreciated the new equipment, especially the delivery beds, which he claimed drew more women to deliver in the maternity. He added that receipt of the equipment had improved the provision of basic care and attracted more sick patients, stating:

> *It really helps us to work better, like for example the delivery bed, the delivery bed we had was already old, when the community saw all the equipment, it started to attract people, and many more pregnant women. When we assembled the delivery bed it was in full view of everyone, it was outside.*

The IT in the HPHC did not know why the HC did not receive equipment from USAID IHP. However, in early 2024, the HPHA received a refrigerator, two solar panels, and a microscope from another IP.

Regarding supply needs, the IT in the HPHC reported sick patient beds, a blood pressure monitor, and clamps, adding that the HC plans on buying these items with revenue, whereas the LPHA mentioned that they had adequate supplies due to the equipment recently provided by USAID IHP. As for maintenance, the LPHC IT reported that they made a monthly inventory of materials and equipment that was shared with the BCZS and tried to clean the equipment regularly. This appeared to be a change since the midline evaluation and may reflect a requirement made by USAID IHP. He also mentioned that defective equipment was managed by the BCZS, and that more costly, non-functional equipment, such as refrigerators and microscopes, were replaced by IPs, which was a change from the responses obtained during the midline evaluation when the IT reported that defective equipment was stored in the HC.

Reference Hospital

USAID IHP supplied the Reference Hospital with extensive equipment, including oxygen concentrators, a manual aspirator, an X-ray machine, autoclaves for sterilization, hospital beds (11), microscopes, surgical lamps, a cesarean section kit, an episiotomy and episiotomy kit (for incision of the perineum to facilitate childbirth), kangaroo aprons, anti-shock outfits for postpartum hemorrhaging, forceps, a stretcher, an electronic device to control intravenous fluids, and thermometers. Although informants appreciated the equipment, not all of it was being used due to insufficient electricity and because health workers were unfamiliar with certain items, such as an electric device to control intravenous fluids. The informants mentioned that USAID IHP staff had promised to provide training, but even after several reminders, at the time of the evaluation, training had not been provided, preventing staff from using some equipment. One hospital informant said:

> *It is necessary to provide training, because if we do not know how to use some material. There are materials that up to today we haven't used, we use what we know. USAID IHP just delivered materials, they did not give any information, for some materials we do not even know the name. We told USAID IHP that we did not know how to use some [equipment], like the electric syringe. We asked many times for somebody to come and give a briefing, but still, they haven't. At least the concentrators, because some doctors already had training, and they showed us how to use it, but the electric syringe, we don't know at all.*

An oxygen concentrator received from USAID IHP had stopped working three months before the evaluation, but technicians did not know how it could be repaired.

Informants reported that the Reference Hospital had all the basic equipment needed to treat children, including scales for newborns and children, height measures, sterilization supplies, thermometers, stethoscopes, and timers. As was the case with the HCs, the hospital had received a new refrigerator before the evaluation. The hospital also had several X-ray machines. However, at the time of the endline evaluation, the blood bank was not functioning. As was the case during the midline evaluation, the hospital did not possess sufficient beds and mattresses in the pediatric ward, forcing sick children to share beds. For repairs, hospital staff contacted technicians in Mbuji-Mayi.

Medications

Both ITs reported that USAID IHP was supposed to provide drug supplies on a quarterly basis to the BCZS based on requisitions submitted by zonal health facilities, and that CODESA members picked up drugs from the BCZS and delivered the medications to their respective HCs monthly. Interestingly, the CODESA from the LPHA mentioned that after delivering the medications to the HC, he was not involved in monitoring drugs at the HC. The IT from the LPHA indicated that service use increased after receiving BCZS drugs because patients know that medicines will be available as part of the treatment package. Head nurses stated that USAID IHP subsidized drugs, with facilities paying 30 percent of the cost of drugs obtained from the CDR.

Head nurses reported the irregular delivery of some essential medicines and products provided by USAID IHP, causing shortages, as well as the failure to fill orders, especially related to the quantity of medicines requested, with the drugs used for MCH reported to be most problematic. ITs mentioned that they replenished essential drugs with medicines purchased at local pharmacies, which were of lower quality, requiring them to charge clients an additional amount to cover the drug costs. They might also give patients drug prescriptions, which mostly occurred in the LPHC because the facility could not afford to resupply the out-of-stock drugs. At the time of the evaluation, essential medicines for treatment of malaria, diarrhea, and cough and cold were available at both HCs, although the LPHA did not have deworming drugs. Medicines reported to frequently experience stockouts included ceftriaxone, amoxicillin, and folic acid. The IT in the HPHA indicated that the low revenue was negatively affected further by ongoing drug stockouts.

Reference Hospital

The HGR had all essential medicines to treat child diseases in sufficient quantity, including zinc, ORS, amoxicillin, ACT and other anti-malaria medicines, vitamin A, and mebendazole. The hospital followed the same approach as the HCs, submitting requisitions for drugs provided by USAID IHP to the BCZS on a quarterly basis, and picking up drugs from the BCZS monthly. Drug quantities supplied by USAID IHP were minimal compared with the needs, with most medicines obtained on the local market. Informants explained that the hospital had a threshold for each product, and as soon as they reached the threshold, the hospital placed an order with a local pharmacy. Supplies to treat malnourished children, including Plumpy'Nut and the F75 and 100 milk, were the products most frequently out of stock for treatment of children.

Use of Services

All types of informants agreed that the main barrier to care seeking at HCs was poverty and lack of financial means to pay for consultation fees, even though the fixed fees in the HPHC were quite low. The LPHC did not have fixed fees, with health workers negotiating fees based on treatment and what the family could afford.

The IT from the HPHA mentioned that due to lack of means, many patients discontinued treatment mid-course.

Other barriers mentioned included self-medication with pharmacy purchased drugs, use of traditional medicines, and visits to prayer rooms in churches, all of which delayed care seeking from facilities. The IT from the LPHC said:

> *Even for small children, they always self-medicate, with modern medicines, but also traditional treatments, it is very rare to see someone who falls ill and is taken directly to the health center. People start with self-medication, everyone you see is a nurse, not a lawyer, not a surgeon, but a nurse. The child falls ill, they give him paracetamol, or buy other medications, sometimes the child is poisoned [with drugs], and when they see that the condition is not evolving or worsens, then they feel that they must bring the child to the health center, but it is already late.*

None of the informants considered distance to be a barrier.

As was the case during the midline evaluation, women in focus groups also reported lack of money as the main barrier to seeking care from the HC. A woman participant from the HPHC stated:

> *When the family does not have money for care, they feel ashamed to go to the health center, except in emergency situations.*

Women confirmed that they were aware of consultation fees, but that the fees were unaffordable for many people, although participants from the HPHA indicated that health workers provided care for young children on credit. Focus group participants reported that some illnesses required other forms of care, such as food remedies or partaking in prayers with pastors. One woman from the HPHA said:

> *The child may have a fever, we take him first to the pastor for prayer and then to the center for care, or to the center first for care then to the pastor for prayer, because there are demonic diseases that require prayer to leave [the body]. They start with convulsions.*

Another mother from the same group stated:

> *The illness Lukunga [stomachache] and Kakela [problem in the throat] push some mothers to use traditional powders for the first, and throat remedies for the second, while other mothers know that they are better treated at the health center.*

Women from the LPHA reported that there were many other facilities in proximity to the HC where they were referred if the HC workers were unable to treat the child's illness.

Reference Hospital

Barriers to seeking hospital care were similar to information collected at the facility level, with informants mentioning that patients often arrived late after administering a mix of treatments and when the condition was more advanced or refused hospital care. Although the fixed consultation fees were relatively low (2,500 CF [1 USD]) with a nurse, 3,500 CF [1.40 USD] with a doctor), treatment costs depended on the drugs and services provided, and prices were considered unaffordable by most residents. Informants reported that many patients were forced to stay in the hospital for days or even weeks after treatment so that they could collect

money to pay for hospital bills.

Management and Governance

Coordination

The head nurses reported holding monthly HA meetings with facility staff, at least one CODESA representative, and a BCZS supervisor to review health indicators and identify ways to improve services. They also participated in monthly BCZS monitoring meetings that may be attended by IPs, but not DPS staff, who they only interact with during supervision visits. The ITs stated that during BCZS monitoring meetings, head nurses presented health indicators, described experiences, and discussed effective approaches with the other HA attendees and BCZS staff, underlining that the BCZS staff encouraged exchanges of information during monitoring meetings. The IT from the HPHA stated:

> *These exchanges are important because they allow others to see where they have made mistakes, we can apply what we learn from others and see if things work a little better. In certain structures, when the IT is absent, everything stops, but this is not the case here, whether I am present or absent, I entrust each nurse with responsibilities. It is this aspect that the BCZS wanted to show to ITs in other structures, to show how to create leadership, so that when you give a task to someone, they do it.*

Head nurses recognized that USAID IHP supported the monthly monitoring meetings, although they were not aware that USAID IHP encouraged more exchanges of information and learning opportunities across HCs. According to both ITs, there were no other formal mechanisms to disseminate or discuss field experiences with other health providers.

Both ITs reported attending monthly CODESA meetings at which community activities were discussed, which they considered an important innovation introduced by USAID IHP. The IT from the HPHA said:

> *I can say that CACs hold meetings. Even the participation of ITs in CODESA meetings, it happened with PROSANI. In the past, it was only during our monitoring meetings that I could share information with the CODESA, but now when I am invited to a meeting in the community, I go, and all that is due to the innovation of PROSANI.*

The CODESA President in the HPHA also mentioned attending meetings with other CODESA presidents in the HZ, as well as participating in BCZS committee management meetings where CODESA members were asked to share HA community activities. The same informant suggested that zonal HCs were in competition and, therefore, reticent to share information on HA experiences, comparing it to sharing household secrets.

Reference Hospital

Hospital representatives mentioned weekly HZ management meetings at which HZ indicators were reviewed, and weekly epidemiological surveillance meetings to review illness trends. Hospital workers only attended DPS meetings involving training or briefings on specific topics.

Accountability Mechanisms

HCs had a free telephone line, referred to as a greenline, introduced by another IP to report gender-based violence. In the HPHA, the IT reported that the phone number had been given to all RECOs and was posted in an obscure area; in the LHPA, the phone number had been removed. Information collected from the HPHA IT underscored some misconceptions about the purpose and the way that the greenline was supposed to be

used. The same IT mentioned that the VIVA intervention involving the assessment of quality healthcare was also considered an accountability mechanism. Only the LPHC had a suggestion box about facility care, with informants mentioning that somebody not associated with the HC came periodically to empty the box and assess the messages. Informants mentioned that problems at the community level were reported to the CODESA President, who subsequently informed the head nurse, who decided what action was needed.

The HPHA introduced community scorecards about a year before the evaluation, and an implementation plan was posted in the HC. As part of the approach, community members had purchased tools (a rake and a spade) to maintain cleanliness in the HC compound.

Reference Hospital

The Reference Hospital also had a suggestion box for clients to submit written suggestions for improvements in services, with informants indicating that most submissions were linked to the high hospital prices. Submission of suggestions appeared to be relatively frequent, although low literacy in the area likely impacted the box's use.

Health Financing

With support from USAID IHP, the HPHA implemented flat rate consultation fees negotiated among the DPS, the HC personnel, and CODESA members who represented community members. At the time of the endline, the same fees were still being used, with treatment fees for simple illness cases of malaria, diarrhea, acute respiratory infection, and TB at 8,000 CF (2.86 USD). The IT reported that increases in drug prices, along with the fact the USAID IHP drug deliveries were irregular and included very few drugs, coupled with decreases in the use of services due to an exodus of residents who were leaving the HA because the government was buying up land to expand the airport, made the fixed fees difficult to generate enough revenue to support health workers and sustain operations. The IT was the only facility worker who received a government salary, and only three of the six workers received a government bonus. Due to these constraints, the IT in the HPHA reported that the fixed consultation fees negotiated at the outset of the program were too low to generate enough revenue to pay health workers adequate remuneration to cover basic family needs and maintain operations, and that the revenue was further affected by ongoing drug stockouts. The same IT expressed frustration that the IPs were primarily focused on setting lower, more affordable prices for community members but failed to consider the livelihoods of government workers, who she stated felt neglected. She said:

> *You see that the partners are leaning more toward the community, but they do not consider the working conditions of the health providers. We are told that you are the state workers, but the state workers do not get paid, how can we live? The support provided should be more balanced.*

It is important to note that revenue in the HPHA was distributed as follows: 40 percent to health workers, 30 percent for the purchase of drugs, 20 percent for operations, and 10 percent for investments.

The LPHC treatment fees were determined on a case-by-case basis depending on the drugs and treatment provided, and the patient's ability to pay, with the IT justifying the approach by claiming that drug costs were constantly rising, making it challenging to offer fixed prices. The CODESA President added that the HC posted consultation fees during the VIVA campaign, which they removed due to increased drug costs. Although the BCZS recommended that the HC institute fixed rates to increase service use, the IT insisted on continuing with

the current approach due to fluctuations in drug prices. The IT reported that HC revenue ranged from 500,000 to 1,000,000 CF (178.57 to 357.14 USD) per month, depending on the season, with the allocation of monthly revenue as follows: 40 to 50 percent for health worker payments, 30 percent for drug purchases, 20 percent for payment to the BCZS, and 10 percent for operational costs and investments. According to the RECO, treatment fees ranged from 8 to 15,000 CF (3 cents to 5.36 USD).

Both ITs reported that they sometimes treated sick patients on credit and allowed patients to pay overtime. Neither HC had a mechanism to cover services for vulnerable patients, although the IT in the HPHC mentioned a social fund that they sometimes used to assist patients without financial resources. No other financing mechanisms, such as mutual health insurance or bonds were used in the HCs, except for a health mutual involving teachers. The IT in the HPHA added that they tried to encourage health mutuals, but the approach was not viable due to the uncertainty of the HC, which was losing clients due to construction at the nearby airport.

Reference Hospital

The administrator reported that consultation fees were 2,500 CF (.89 USD) with nurses and 3,500 CF (1.25 USD) with doctors, but that the treatment costs for outpatients depended on the drug regimen prescribed, adding that malaria drugs were free. Hospitalized cases were often retained in the hospital, sometimes for several weeks, to allow them to pay for hospital treatment. The IT in the LPHC said that the Reference Hospital had a reputation for being expensive, with the hospital clinician reporting that in-patient treatment fees are generally 280,000 CF (100 USD) or more. The same informant mentioned that the hospital administration was trying to identify approaches to increase service use and revenue, with the hospital exploring establishing fixed fees. No other financing mechanisms existed, although the hospital staff attempted to start a health mutual that did not last. All operational costs and investments, which recently had included extensive renovations and painting, were financed through hospital revenue.

Resources for Facility Workers

The HPHC had nine workers, including two nurses at the A1 level and one laboratory technician at the A1 level, three nurses at the A2 level, two cleaners, and one guard. The LPHC had 10 staff, including one L2 level nurse, two nurses at the A1 level, two nurses at the A2 level, one A3 worker, one lab technician at the A2 level, 2 female cleaners, and one guard.

Training

The IT from the HPHC reported that nursing staff had participated in several training sessions sponsored by USAID IHP since the midline evaluation, including training on how to manage postpartum hemorrhage (one staff) and community distribution of sulfadoxine-pyrimethamine (SP) to prevent malaria in pregnant women. In addition, two staff members attended refresher training as part of mentoring clinic focused on MCH care. The IT in the HPHC considered USAID IHP-sponsored training to respond to HC needs and of high quality, equipping staff with lifesaving skills. LPHC personnel appeared to have participated in fewer recent USAID IHP-financed training opportunities, with the IT only mentioning training on maternity care. Neither head nurse reported recent USAID IHP- supported training on childhood illnesses. Personnel in both HCs mentioned attending recent training offered by other IPs, such as training on financial management.

Reference Hospital

Hospital informants reported that before the midline evaluation, workers participated in several training

programs on maternal care (Basic Emergency Obstetric and Neonatal Care; Emergency Obstetric and Neonatal Care at the Health Center Level; and Emergency Obstetric and Neonatal Care at the District Level) offered by USAID IHP; they also mentioned more recent training on maternal and neonatal health provided through the mentoring clinic. There was also mention of recent training on TB, surgery, safe blood transfusions, malaria treatment, institutional management, and financial management, but they were not clear whether USAID IHP offered the training. There was also drug management training offered by USAID IHP.

All types of informants expressed the desire for more training opportunities, with clinicians mentioning that the medical field was constantly changing, and that they needed to stay up to date on treatment practices. In future, USAID IHP should attempt to improve their visibility so that they get appropriate credit for their extensive training efforts.

Supervision

HC ITs mentioned that they received monthly supervisory visits from BCZS personnel who assessed health services and data quality by comparing monthly indicators with the data reported by the HC and focused on problems detected during monthly monitoring meetings. Reference Hospital informants also reported receiving monthly BCZS supervisory visits during which recommendations were made to address deficiencies in hospital care, with one informant mentioning that USAID IHP financed these visits.

Access to Continuing Education

Facility-based health workers reported primarily receiving health-related information during meetings, training, and through the Internet, which they accessed on their personal phones. They stated that they had limited access to updated health information, which affected their work capacity. Informants did not report any changes in access to health information, which they considered essential, since the start of USAID IHP.

Attitudes of Health Workers

Informants reported that health workers were generally welcoming and treated patients well. However, there were reports of occasional bad behavior, although rarely when interacting with patients. Several informants stressed the importance of maintaining good relations with community members, who were their clients, with the CODESA President from the LPHA stating:

> *If you scold and get angry, it will make everyone run away from you, in the community they will say that in the health center they scold the sick, there is this and that in their center. These are the kinds of subjects that we deal with during meetings with the health workers. We emphasize showing restraint in front of sick patients, because there are times a sick person arrives with an illness that gives him trouble in his head, and he may tell you anything.*

Informants mentioned that community members shared negative interactions with RECOs or with the CODESA President, who subsequently contacted the head nurse in charge of addressing the problem. The head nurse from the HPHC reported participating in a training sponsored by USAID IHP before the midline evaluation on attitudes of health workers, and the IT in the LPHC mentioned that he was recently interviewed by a USAID IHP consultant on interpersonal dialogue between health workers and patients, but he had never participated in the training. The IT from the HPHC reported that the VIVA quality healthcare intervention had provided valuable information on health worker behavior.

General Reference Hospital

Hospital informants did not report any inappropriate behavior manifested by health providers when interacting with patients or child guardians.

Health Worker Sources of Motivation

According to the two ITs, remuneration was the primary motivation for health workers to provide quality care and work hard. In the HPHC, only the IT received government salary, which had started in late 2023, although other workers were officially registered on the government payroll; three of the eight workers received a government bonus. As mentioned, the IT stated that increased drug costs made it difficult to generate sufficient revenue to adequately motivate the health workers who were becoming more dissatisfied, recommending that the IPs consider health workers when devising strategies. In the LPHA, three of the 10 workers received both a government salary and bonuses, and the IT received a bonus, which he reported was 163,000 CF (58.21 USD). He described the bonus as a pittance, claiming that based on his qualifications, it should be 500,000 CF (178.57). Both HCs used monthly revenue to pay their workers at the end of the month, apportioning payments according to fixed percentages linked to health worker qualifications. The IT in the LHPA reported that revenue varied across seasons, with the HC accumulating from 500,000 to 1,000,000 CF (178.57 to 357.14 USD) monthly. He stated that only health workers receiving government salary and bonuses were satisfied, and that the constat turnover of workers reflected their displeasure with payment.

Regarding work advancement, the IT from the HPHA lacked interest in advancing to the status of BCZS supervisor, who she reported relied on small payments generated from activities like supervisory visits. The other IT said that there were few opportunities to advance, thus reducing ambition and affecting work ethics. The ITs reported that USAID IHP contributed to capacity building, which increased knowledge and quality of care, although opportunities were limited, with most workers only exposed to post training briefings. The IT in the LPHA added that the drugs subsidized by USAID IHP helped increase monthly revenue, although drug delivery was irregular and inadequate. The IT in the HPHA reported that she was not happy with USAID IHP support, explaining that since the start of USAID IHP, it had gotten more difficult to maintain operations in the health structure partly due to the fixed consultation fees. Both ITs mentioned that the registers and forms distributed by USAID IHP had helped them in their work and reduced some expenses.

Reference Hospital

The hospital apportioned local revenue to health workers based on their qualifications, notwithstanding whether the worker received government salary. An informant reported that monthly revenue could fluctuate substantially, and that some workers did not understand the math determining the amount of money allocated. One informant mentioned being promoted after three years of work, and that the hospital was trying to promote workers. Regarding USAID IHP, informants considered the training offered, which was mostly focused on maternity care, as a form of motivation, adding that USAID IHP also provided money for health workers to attend monitoring meetings and lead supervision visits.

Community Health Services

Infrastructure

Health Areas

Informants described the community structure as comprised of CACs established in 2020, which were supposed to include eight elected RECOs. Eight CACs existed in the HPHA and there were nine CACs in the LPHA. With support from USAID IHP, CACs and CODESA committees had been revitalized three times in the

LPHA and two times in the HPHA since the start of the program. Following specific criteria, BCZS staff assisted with the organization of the election of RECOs to represent CACs in their communities. Informants reported that CACs were comprised of a president, vice president, treasurer, secretary, and advisors, with the CAC president also a member of the CODESA committee. Informants mentioned that many CAC presidents and vice presidents were women.

CAC leaders held monthly meetings to discuss community health activities, share monthly reporting, and identify health-related problems, with the CAC presidents, who were considered the focal points between the community and the HC, responsible for sharing health-related information from their CAC during monthly CODESA meetings. Informants indicated that CACs were facing challenges maintaining sufficient numbers of RECOs, with informants reporting only three to five RECOs in each CAC due to the fact that the work required a lot of time but lacked payment needed to support their families. The IT from the HPHA said, “Out of eight CAC members, most CACs have three to four members who are active. People don't want to hear about volunteering anymore.” Informants reported that some IPs supported the introduction of income generating activities, such as rabbit and poultry raising, or made financial contributions so that CACs could maintain cash. In addition, RECOs were requested to contribute small amounts of money that they occasionally received from IPs. The money, which was controlled by the CODESA committee, was supposed to be used to purchase supplies, such as paper and pens to conduct monthly work.

Community-based activities focused on a variety of key health issues, such as FP; child vaccinations; identification of patients with different pathologies, such as TB; distribution of SP for prevention of malaria in pregnant women; and screening of children for malnutrition. USAID IHP-financed FP involved the promotion of birth spacing and the distribution of contraceptive methods in the HPHA. CHWs used different approaches to carry out their work, including the use of megaphones to disseminate information, the conduct of in-home visits to assess the health status of community members, the identification and referral of sick patients (especially children) to health facilities, and targeted screening for specific conditions (e.g., TB, unvaccinated children, malnourished children). Messages were disseminated at the community level, but also in churches and schools, but radio was not mentioned. The IT from the HPHA praised the community activities, mentioning that community actors disseminated key messages to masses of people.

Informants reported that HC nurses from the two HAs led outreach activities involving child vaccinations. Although the nurse informants claimed to conduct household visits, the CHWs agreed that the only other time that facility workers went to villages was during mass campaigns, such as for vaccinations or mosquito net distribution. A RECO from the LPHA said:

> *Nurses only go to the community during vaccinations in the outreach sites. That is when we go with them, we convoke the children and their parents, the nurses do health education. We also teach them about the mistakes made to children who miss vaccinations. We tell them that the child should receive all the vaccines up to nine months and come back at 15 months for more vaccines. Sometimes we find children who are already two years old but have not received the measles vaccine.*

Only the LPHA had a functional iCCM site, which was created in 2014 and operated by a female and male RECOs. When the evaluation team visited the iCCM site in 2022, iCCM activities were carried out under a tree. Since that time, the community had built a hangar for activities. The iCCM site had essential equipment and materials to carry out the work, including a table, four chairs, and a medicine cabinet, as well as registers,

counselling forms, essential drugs, and rapid malaria tests, with the iCCM provisioned drugs monthly. A review of the register showed that visits of children were regular, and referrals of sick children, particularly cases of malaria, were being made to the LPHC. In addition, the RECO reported that they received monthly supervision visits. Due to the high performance of the iCCM site, the USAID IHP staff in Kasai Oriental had selected the female RECO to represent the program during a conference in West Africa; although the RECO flew to Kinshasa, her passport was never issued, and she was unable to travel.

Neither health area had a community nutrition group. Women from the HPHA mentioned that culinary demonstrations had been held in the past but were discontinued because participants were unable to afford to purchase ingredients. Community scorecards had been introduced in both HAs but was no longer functioning in the LPHA.

Mass campaigns involving the distribution of bed nets, vaccinations, vitamin A, and mebendazole occurred periodically, which was confirmed by participants in both focus groups. Only informants in the LPHA reported the conduct of mini-campaigns, which they reported were carried out once or twice annually and focused on such topics as FP and TB. Informants did not mention any local organizations, aside from CACs, currently working in the health sector, but identified several technical and financial partners in both HAs.

Both HCs had flip charts available for educational sessions during ANC and CPS sessions, with CHWs explaining that they used flipcharts to present information on a wide range of topics (e.g., exclusive breastfeeding, malnutrition, TB, HIV, FP, danger signs during pregnancy) covering 24 key messages. Maintained in the HCs, the flip charts included images with corresponding messages and question prompts to guide information sharing. Informants reported that Tshiluba sub-captions, which were recently introduced, were very helpful in ensuring standard messaging, also underlining the importance of conveying information in the local language.

System Design

Role of CODESA Members

Informants uniformly described CODESA members as a bridge between the health facility and the community responsible for ensuring information sharing between community members and health providers. CODESA members, who were CAC presidents, collected information on the health needs of community members and relayed this information to health facilities during monthly HC and CODESA committee meetings. Informants mentioned that these meetings had previously been sponsored by USAID IHP, which had initially provided 20 USD that decreased to 5 USD over time, with informants reporting that for about a year, they were no longer receiving USAID IHP support. In addition, CODESA members were responsible for sharing information from the health facility about upcoming events and health concerns with community members. CODESA members were also responsible for transporting drugs from the BCZS to the health facility, although the CODESA member in the LPHA mentioned that they were not involved in monitoring HC drugs and supplies. CODESA members also helped organize prenatal, preschool, and advanced health visits. Informants reported that CODESA members did not receive basic supplies, such as pens and notebooks needed for their work, but rather used the cash raised by CACs to purchase materials.

With CAC revitalization, the election of CODESA members was carried out throughout the HZ of Bipemba in 2020, with subsequent elections carried out every two to three years. The HPHAs had an eight-member committee, comprised of two female members serving as vice president and treasurer, and the committee of the LPHA included five women and four men, and the president was a woman.

Role of RECOs

Informants reported that the primary role of RECOs was to conduct home visits to monitor the health status of community members, especially children, and to identify and refer sick household members to the HC. In both HAs, RECOs were responsible for following 25 households. Other responsibilities included raising awareness about different health themes, including hygiene and sanitation practices; child vaccinations; FP methods and the importance of birth spacing; and the main causes of child morbidity and mortality, including malaria, diarrhea, and pneumonia. RECOs assisted health providers during prenatal, preschool, and advanced health visits, during which they led education sessions and assisted with growth monitoring. RECOs were also involved in specific activities funded by IPs, such as the recovery of children with zero vaccinations or who had missed vaccinations; distribution of SP to pregnant women; illness surveillance of different pathologies, including TB; FP activities; and screening for child malnutrition. They also participated in both mass and mini-campaigns, with mass campaigns providing opportunities to earn money.

Informants mentioned that it had become more difficult to retain RECOs, with many joining under the misconception that they would be paid. A RECO from the LPHA said:

> *In our CAC, there were eight of us. But we experienced a lot of difficulties, because when I agreed to join the RECO team, many others thought that community relays were paid at the end of the month, or when a RECO works at the health center he is paid. They did not understand that the work of community relays is voluntary, it is to help the community.*

Informants explained that many RECOs needed to travel for their income generating activities or were unavailable due to subsistence work and, because of ongoing work requirements, they abandoned the work.

The HPHA included 64 RECOs, with 33 men and 31 women. However, 30 of the 64 were active, and only 15 were formally trained. The LPHA had 72 RECOs, including 30 female and 42 male RECOs, although only 32 were active. Both HAs reported that CACs included some young RECOs, but the numbers were small, with informants mentioning that young people were particularly hard to retain as volunteers.

Informants underscored the importance of maintaining good relations with community members, stating that conflict involving CHWs was rare. The CODESA President from the HPHA added that RECOs were elected by community members based on their positive characters, mentioning that they targeted community members who were well liked. The CODESA President from the LPHA said:

> *We don't quarrel with the sick. If you happen to quarrel with a sick person, community members will chase you away and say, "No, don't come here, you quarrel with people."*

Reported negative behaviors exhibited by RECOs were generally associated with issues related to the lack of motivation or being cheated of per diem that was promised during mass events. CHWs mentioned that they addressed occasional mishaps during CODESA or CAC meetings.

Focus group participants reported that RECOs in their villages carried out regular household visits during which they shared information about services offered at the HCs, such as childhood vaccinations, distribution of bed nets, and Plumpy'Nut, as well as messages on exclusive breastfeeding, the importance of vaccines for young children, and the importance of and proper use of bed nets. Women reported that they appreciated the information, especially when they were informed about services at the HCs. Other places to access health

information included in church and through the radio. Although fewer than 20 percent of women participants owned a radio, some focus group participants mentioned hearing emissions about healthcare similar to those transmitted by the RECOs, but also including messages on maintaining harmonious couple relations. Many women in the HPHA focus group had a telephone, reporting that they received messages sent through Orange on childhood vaccinations.

Specific Services Offered

Bed Nets

Informants from both HCs indicated that bed nets were distributed to pregnant women during their first prenatal consultation and during the preschool visit when children received their first measles vaccine at nine months. In the LPHC, women delivering at the HC were also eligible to receive a bed net. HCs received bed nets from the BCZS every two to three months, but in the LPHC, the IT reported occasional stockouts. Mass bed net distribution occurred every three years, with informants mentioning that they were not given enough bed nets to meet the demand.

Reported challenges to bed net use included that the dimensions of local homes were too small to hang the bed nets or that residents found that it required too much work to hang the net, or that bed nets were used for other purposes, such as a mat, bed cover, or to contain animals or poultry.

Women participating in FGDs confirmed that bed nets were distributed during the first ANC visit and when children received what they referred to as the last vaccine at nine months of age. Participants referred to a mass distribution in 2023 (LPHA) and 2024 (HPHA), although they expressed dissatisfaction that nets were not given to all household members. When describing the use of bed nets, one woman from the HPHA said:

> *We make our children sleep under the mosquito net, the mosquito net is not to use as an enclosure, nor to cover the shower, nor to decrease the pressure from rainwater, but the mosquito net is to protect against mosquitoes.*

Vaccination

HCs offered childhood vaccines during CPS sessions every Wednesday and outreach sessions to distant HA villages, with the HPHA conducting outreach weekly. Both HC ITs also reported administering vaccines on Fridays to children who had missed vaccinations, with the HPHC IT claiming that vaccines were given anytime to children who had missed vaccinations. The same IT mentioned that USAID IHP provided essential assistance in setting up cold chains in the HZ, adding that her HC now had two functioning refrigerators. She reported that with a functioning cold chain, it was much easier to “recover” children who had missed vaccinations, stating:

> *Before there was only one health area that had a cold chain, so all of us were forced to get supplies from the BCZS. Now that we have cold chains, when we have a child in front of us who has missed a vaccine, we have the vaccines in the HC, and we vaccinate the child directly.*

The main reported challenge related to ongoing stockouts of vaccines, especially BCG, which at the time of the endline evaluation was experiencing a provincial-wide stockout that had more than over four months. OPV was also out of stock. The IT in the LPHA explained that since the government had taken charge of purchasing BCG and OPV, stockouts had persisted, adding that they had a list of 120 children who had missed these vaccines. Informants generally denied vaccine resistance related to cultural or religious beliefs. The IT in

the HPHA stated that mothers sometimes objected to their children receiving multiple injections during one visit.

Child caregivers in both focus groups reported that children completed vaccinations at nine months of age, which contradicts the current vaccine calendar. They mentioned a reduction in vaccine stockouts, except for BCG, which commonly experienced shortages for long periods. Women in the HPHA considered awareness raising in the HC as extremely effective in convincing people opposed to vaccinations to get their children vaccinated.

VIVA Approach

Informants from both HAs reported that when BA led VIVA activities from 2021 to 2022, training on a variety of thematic areas (e.g., TB, nutrition, FP, vaccinations, WASH, exclusive breastfeeding, bed net use, prenatal care) had been offered, and that BA staff were frequently present in their HAs. VIVA interventions mentioned that were implemented between 2021 and 2022 included cost comparisons, savings boxes, couple meetings, listening clubs, and quality HC, with informants insisting that the VIVA approach was effective in motivating behavior change. Informants recognized that VIVA activities had been transferred to USAID IHP, claiming that since the departure of BA, USAID IHP personnel had not been involved in VIVA interventions, and training was no longer offered. Informants reported that the only behaviors that community members continued to follow included improved savings and management of funds for family health needs, although the evaluation team was unable to verify whether families had changed their cash savings practices. The data collected indicated that VIVA interventions were no longer being implemented in the HAs, and there was scant mention of messages disseminated on the radio.

Community Health Worker Motivation

The community-based workers interviewed, all of whom had been in their roles for several years, uniformly stated that they worked to improve the health of community members, with most underlining a strong commitment to their work. They mentioned occasionally receiving incentives involving 5 to 20 USD for participating in campaigns or monthly payments to lead specific activities, such as distribution of contraceptives, identification of children missing vaccinations, or identification of TB cases. A RECO from the LPHA said:

> *As I am a volunteer here, my concern is to master the work, knowing how to do the work is more important than money. I cannot prioritize money; above all, it is knowing how to do the work…I cannot make conditions to work for a salary, because I had already agreed to be a volunteer.*

CHWs also reported receiving per diem when participating in training. A CODESA member from the same HA said:

> *This is a job that we have done for several years, so we are already very used to it. Even if I do not earn something today, I do not make a problem about it. I know that sometimes I will benefit from something. Sometimes we participate in training for two or three days. At the end they give you your 10 USD per day, and when you multiply 10 USD times three days, it reaches 30 USD, which can really help.*

There was agreement that USAID IHP had provided limited training for community workers, with the CODESA President of the LPHA mentioning that after the CAC revitalization, there was no training, thus impacting on

the work quality. He said:

> *PROSANI [USAID IHP] should think of us, give us training, because since we were revitalized and until now, there is nothing. Those who have come recently, new RECOs, they do not know anything. and it is since 2020 [the start of USAID IHP in the HA] that we have not received training. It creates difficulty, because the new RECOs need to understand the work…Among us there are some who know nothing, which discourages those of us who have been trained.*

Although the CODESA Presidents claimed to have never participated in training sponsored by USAID IHP, other RECOs mentioned training sessions likely introduced by the USAID program on SP distribution, illness surveillance, screening for TB cases, FP, and the recovery of children missing vaccinations. Often informants were unable to identify the IP sponsoring the training, once again underlining the need for USAID IHP to increase its visibility.

In particular, the CODESA President from the LPHA expressed dissatisfaction about the lack of assistance from USAID IHP. In general, there was consensus that USAID IHP contributed far less to community activities compared with former IPs, leading to displeasure and high turnover of RECOs. CHW informants consistently expressed a need for more training to strengthen CHW capacity and motivation.

Kasansa Health Zone, Kasai Oriental Province

In the HZ of Kasansa, the assessment was conducted in the same HPHA and a LPHA evaluated during the midline evaluation. The original selection of the HAs was based on child health indicators, such as HC attendance for major child diseases and immunization. In each HA, in-depth interviews were conducted with the IT, a CODESA member, a RECO, and the RECO in charge of the iCCM site. Although the evaluation guidelines generally required more than one interview with the ITs, both ITs were not available for follow-up interviews, and we carried out subsequent interviews by phone. It should be noted that one of the ITs was inebriated during the initial interview. Unfortunately, we were unable to interview hospital workers.

All FGD participants were mothers of young children.

Background Information

The mean age of respondents participating in the in-depth interviews was 49 years old, the majority of whom (7 of 8) were men. The ITs, CODESA members, RECOs, and the RECO in charge of the iCCM site had an average of 14 years of education. Respondents had an average of ten years of work experience in their positions. All informants had other occupations, most often related to agricultural activities. The average number of people living in informants' households was ten.

Facility-Based Services

Infrastructure

The HC in the HPHA was built between 2017 and 2018, made of adobe bricks, and in need of renovations. At the time of the midpoint evaluation, the IT reported that the HC had begun taking steps to build a new building, but nothing had been done since 2022. Comprised of two rooms, all sick patients were treated in a small, cramped room. There was no laboratory or maternity ward. During the rainy season, a cistern was used to collect rainwater, but during the dry season, no water was available at the HC. As was the case during the

midline evaluation, the HC used solar panels for electricity. Before the midline evaluation, USAID IHP had supported the construction of improved latrines and an incinerator at the HC, although at the time of the evaluation, the incinerator was damaged. The HA included three villages divided into six CACs, and did not have a functional iCCM post.

The LPHC was in an isolated area about seven kilometers off the main road and 14 kilometers from the HGR serving the HZ of Kasansa. Constructed two years before the midline evaluation, the HC was spacious and consisted of separate rooms for consultations and care, a pharmacy, a functional laboratory, and a maternity ward. According to the head nurse, it complied with government norms. Both adults and children were treated in the same consultation room. The HC had separate latrines and showers for men and women constructed with support from USAID IHP before the midline evaluation, and since the midline, the EU had provided additional support for construction of more latrines, pits to discard biomedical waste, and an incinerator. The HC had two water tanks with a 1,000-liter capacity each, and used solar panels to generate electricity. Comprised of nine villages, this HA had seven CACs and a functional iCCM site.

Services Offered

Health Centers

The two ITs reported that they offered a minimum package of primary healthcare services, including outpatient treatment consultations, minor surgery, CPN, CPS, FP, and vaccinations, and the LPHC offered maternity care. Although both HCs carried out passive and active screening for malnourished children and were supposed to offer treatment for severe child malnutrition, since 2022, the LPHA did not have treatment supplies. The HPHC referred pregnant women to the hospital one kilometer away for delivery and relied on the HGR for laboratory tests. Only the HPHA reported that USAID IHP assessed the availability of quality integrated services, which had most recently occurred in 2022, but at the time of the midline evaluation, was carried out by the EU.

Both ITs indicated that they used an integrated approach when treating children, which involved following flowcharts and protocols for case management of child illnesses. It was introduced in 2021 when health workers received training and tools from USAID IHP. The IT from the HPHC mentioned that due to drug shortages, sometimes they were unable to follow treatment protocols. The two ITs reported that during treatment consultations, health workers also provided preventive messages related to essential practices according to the child's condition and age. Head nurses stated that CPS sessions involving growth monitoring also included educational sessions focused on prevention of childhood illnesses and nutritional intake. Sessions were held several times a week in the HPHC, with a total of 12 outreach visits carried out in the four HA posts monthly. The schedule in the LPHC was different, with a CPS session held one week at the health facility, and the following week, an outreach visit was carried out in one of three villages where outreach was held. Head nurses reported that ANC visits could be made by pregnant women anytime.

Focus group participants described the services offered at the HCs to include medical treatment, vaccinations, and preventive approaches focused on information sharing designed to protect against common childhood illnesses and malnutrition, such as the importance of using bed nets, exclusive breastfeeding, and good dietary intake. Although women valued the information shared, they indicated that limited resources often prevented them from complying with the messaging. A woman from the LPHA said:

> *We accept the information, but the problem is our limited resources, you might have money to follow the recommendations for one day, the day after the money is gone, and you are unable to find even a small quantity of flour for porridge.*

A woman from the HPHA agreed, stating:

> *We know that when we do not follow the health worker recommendations, our children will end up getting fat cheeks, but our main problem is lack of money.*

Women in the LPHA also mentioned that the HC offered ANC visits and maternity services.

Women participants conveyed appreciation that HC nurses had good medical knowledge and treated them directly without asking for payment, reporting that the treatment provided quickly reversed illnesses. Despite this, women from the LPHA admitted to first administering traditional remedies or drugs purchased in the market before taking their sick children to the HCs.

Equipment

Both HCs had two functioning solar powered refrigerators. The HCs had growth monitoring kits, including a height measure, Salter scales and MUAC bands, and a scale for adults. The HPHA did not have a baby scale, and the baby scale in the LPHA was in a poor condition and could potentially injure children during weighing. Facilities had working stethoscopes, blood pressure monitors, sterilization equipment, thermometers, and timers. The LPHC had a treatment table for children, whereas the HPHA did not. Other equipment in the LPHA included a fetoscope, a microscope, and an electric centrifuge with all reagents. HCs had handwashing stations, and both HCs had one motorcycle for travel needs. Neither HA had received equipment from USAID IHP.

When in need of equipment, ITs reported submitting a request to the BCZS that was forwarded to the EU, with the IT in the HPHA reporting that they were not authorized to buy missing equipment or materials based on an agreement with the EU. Regarding repairs, ITs explained that the contract with the EU included a clause to earmark a percentage of the HC revenue to support equipment maintenance. Both ITs reported that they had to send the piece of equipment to the BCZS, which contacted provincial- level authorities who were responsible for deciding who would carry out the repairs. As was the case during the midline, both ITs reported that they were missing basic equipment necessary to provide essential health services to children.

Medications

The HZ of Kasansa received malaria medications from USAID IHP, with other drugs supplied by the EU, which transferred funds for each facility to their respective account at the CDR when orders were made. Informants reported that delivery of malaria drugs by Chemonics International occurred quarterly, with USAID IHP supporting “last mile” delivery. The CODESA from the LPHA picked up the drugs, whereas in the HPHC, the IT collected drugs from the BCZS.

The head nurses reported that the drugs provided by the EU were consistently delivered late, and that both USAID and the EU provided far fewer drugs than indicated in purchase orders, leading to stockouts of malaria and other medications, which can last for weeks. The HPHA head nurse mentioned recent shortages of amoxicillin and other critical antibiotics. Stockouts caused by the late delivery of medications and the failure to meet drug requisitions forced health workers to give patients prescriptions to buy medications locally. This practice contravened the signed agreement with the EU, which prohibited HCs from purchasing medications

in the local market or giving drug prescriptions to patients. ITs reported that stockouts of medications negatively impacted HC revenue and operations.

At the time of the evaluation, both HCs had essential medicines including zinc, ORS, amoxicillin, ACT and other anti-malarials, vitamin A, and mebendazole for treatment of childhood illnesses, as well as malaria diagnostic kits.

Use of Services

As was the case during the midline evaluation, informants considered poverty to be the biggest obstacle to care seeking at facilities, stating that many people were unable to afford the set consultation fees, which for children were 10,000 CF (3.57 USD) in the LPHA and 5,000 CF (1.79 USD) in the HPHA, representing an increase in fees likely associated with the devaluing Congolese Franc. Health workers from the HPHA reported that even if they did not have money, community members were encouraged to seek treatment at the HC, where health workers could diagnose the condition and provide treatment on credit. Informants indicated that not all people accepted treatment on credit out of concern that they would not be able to repay the debt. Those who already had a debt with the health facility were ineligible to receive care until the debt was paid.

Informants mentioned distance as another obstacle, especially in the LPHA where villages were as far as 15 kilometers from the HC. Informants also mentioned widespread use of traditional medication and pharmaceuticals, which community members used without knowing the illness diagnosis or treatment dose, which could cause harm and delay formal treatment from facilities. There was also mention of treatment seeking with pastors who could sequester ill patients over dangerously long periods while they carried out non-medical practices to address the perceived cause of the condition. A RECO from the HPHA said:

> *Yes, pastors tell people that illnesses come from demons, they do not understand that the body may be exposed to something that can cause illness. Some pastors advise that before going to the hospital, you must see the pastor who can pray for the sick person. Some religious people ask guardians to stay with the sick child in the church where the pastor will chase away the demons.*

Informants from both HAs mentioned that RECOs were tasked with discouraging community members from using indigenous medicines or self-treatment due to the dangers of ingesting toxic substances and/or inappropriate doses, emphasizing the importance of seeking biomedical care from facilities where the illness could be diagnosed. The RECO from the HPHA also encouraged people seeking prayers to avoid long delays in care seeking from facilities.

Women in the focus groups confirmed that the lack of resources to pay for consultation fees and medications were the main obstacle to seeking care at the HCs. Caregivers consistently complained about shortages of medicines at the HC, causing health workers to give drug prescriptions, which involve additional costs. A woman from the LPHA said:

> *The center should have medicines and avoid issuing prescriptions, which discourages patients from visiting the center. They think if they go to the HC, they will receive a prescription which they are tired of. Issuing prescriptions is often the case at the center.*

Women from the HPHA offered the following statements:

A child can become sick, but the mother does not have the possibility of seeking care. Another mother can have 5,000 CF when she arrives at the center, they give her a prescription for 20,000 CF, now what will she do? Will she bring the child to the center and sleep hungry or sell some clothes to raise money?

There never has been treatment without adding prescriptions, there is no free treatment.

Attendees from both groups reported that community members sometimes opted for other forms of healthcare, such as traditional healers, drugs sold in the market, or preachers who pray for the ill patient, with preachers often consulted when unusual illness signs, such as convulsions that may be linked to the supernatural, were involved. Some people might seek care at alternative HCs offering biomedical care.

Management and Governance

Coordination

According to informants, personnel in both HCs and the CODESA Presidents participated in weekly meetings during which health indicators are reviewed, decisions were made about upcoming activities, and a report was generated and sent to the BCZS, with informants indicating that the BCZS responded with feedback the following day. Informants mentioned that during these meetings, they examined the performance of the CACs and made decisions about how to support those CACs experiencing problems. In addition, informants reported that the HAs held monthly monitoring meetings involving facility personnel and CODESA representatives who reviewed and compiled monthly data, which were subsequently submitted to the BCZS. BCZS monitoring meetings were attended by all HA head nurses, BCZS staff, and a DPS representative, and CODESA members were invited to attend when challenges related to community activities arose and needed to be discussed. Head nurses explained that during monthly monitoring meetings, each HA presented health indicator data, and subsequent discussions ensued about ways to improve health services based on the recent data. The head nurses considered these exchanges as valuable ways to share experiences and learn from other approaches used by health workers in the zone, with weaker HAs benefiting from information from those HCs that were higher performing. Aside from interactions during the monthly zonal meetings, the head nurses did not have other opportunities to interact with DPS officials. It should be noted that during our evaluation, USAID IHP organized a meeting of all Kasai Oriental HZs to analyze and validate their quarterly data.

Both head nurses mentioned participating in community development meetings twice monthly, which often involved discussions on local projects. The HPHA head nurse reported attending meetings focused on installation of a water structure and construction of a building to hold CPS sessions.

Informants reported that CACs were supposed to hold monthly meetings where they generated a report based on community activities, which was submitted to the CODESA President. However, head nurses reported that these meetings were not held regularly. CODESA members, which include all HA CAC Presidents, held monthly meetings during which they shared information with all CACs.

Accountability Mechanisms

The HPHC had three fraud telephone lines, although one of the numbers was not working, whereas the LPHC had one telephone line; phone numbers were posted in an obscure location not visible to patients. None of the telephone lines had been introduced by USAID IHP. Aside from the ITs, who reported that the telephone

lines were available to report fraud, evaluation informants were unclear about their purpose. HCs also had suggestion boxes through which community members could submit comments on health provider attitudes and behaviors, although according to our informants, the suggestion boxes were rarely used. A separate committee oversaw the suggestion boxes responsible for collecting and reviewing the complaints, about one time a quarter, and sharing results with the BCZS. Interestingly, the CODESA President mentioned that the CHWs were not permitted to submit complaints. As was the case during the midline evaluation, the accountability mechanisms introduced by IPs were not functioning as planned, with the IT in the LPHA discouraging the use of mechanisms to monitor health services.

The CODESA President from the LPHA mentioned that he shared complaints shared by community members about healthcare with facility workers and advised community members when they had behaved inappropriately with HC staff. He emphasized the importance of maintaining good relations between the HC staff and people using health services by sharing feedback and interpersonal counseling.

Health Financing

At the time of the endline evaluation, the HZ was supported by the EU PBF approach. This was a big change from the midline evaluation when facilities relied solely on HC revenue to cover monthly operational costs and remuneration of health personnel. Informants reported that EU performance payments were initially received monthly as spelled out in the formal agreement, but that since 2022, payments had become irregular and late, and were given to cover several months rather than monthly. Head nurses mentioned that late payments, which were supposed to be 487 USD in the HPHA and 250 USD in the LPHA, along with the failure to meet drug requisitions and late delivery of medications, disrupted HC finances, especially the payment of health workers.

Informants indicated that in 2023, consultation fees had been negotiated with the BCZS staff, HC personnel, and CODESA members representing the community. Flat fees were posted in the HCs, although in the LPHC, the posted fees were placed behind a door. Consultations for children were 10,000 CF (about 3.60 USD) and for adults 15,000 CF (about 5.40 USD), whereas in the HPHC, fees were 5,000 CF (1.79 USD) for sick children and 10,000 CF (3.57 USD) for adults. Since the midline evaluation, this represents about a 50 percent increase in service fees in the HPHA, and more than a 100 percent increase in the LPHA, which likely reflected inflation of the CF, although the IT in the LPHA justified the increase by stating that the lower fees were unable to generate enough revenue. Although consultations fees were supposed to cover drug costs, ongoing stockouts forced health personnel to give patients prescriptions to purchase drugs locally, which informants stated poor community members were unable to afford. In addition, although the HCs offered care on credit, people who already had a debt were not eligible, preventing them from obtaining facility care.

Head nurse informants indicated that monthly revenue was divided as follows: 50 percent for payment of personnel, 30 percent for drug purchases, 10 percent for operational costs, and 10 percent for facility investments. The IT from the LPHA reported that the HC typically generated 500 USD per month, which he claimed was lower than before the start of the EU PBF approach, along with 250 USD contributed by the EU. Given that there were seven health workers in the LPHC, on average, workers earned about 54 USD monthly. The CODESA informant in the LPHA indicated that the EU agreement included monthly payments for CHWs, which was not being followed, with the CODESA member suggesting that the head nurse was taking the money.

Head nurses reported that there were no other mechanisms to finance healthcare, such as health mutuals or bonds. In addition, no support was provided for vulnerable community members.

Resources for Facility Workers

The HPHC had eight workers, including one nurse at the A1 level, four nurses at the A2 level, one receptionist, one archivist, and one cleaner. Among nursing staff, three were men and two were women; in total, there were four men and four women workers. Comprised of seven workers, the LPHC had three A1 level nurses, including a midwife; one A2 level nurse; a receptionist; and two cleaners, of whom four were men and three were women. The women included two cleaners and a midwife. Neither HC met government health personnel standards.

Training

The HPHA health workers had participated in one training from 2023 up to the time of the endline evaluation, which focused on the use of FP methods to reduce undesired pregnancies and maternal death, with two HC workers having attended the training. During the same period, health workers in the LPHA had participated in one training focused on maternity care and one training course on laboratory techniques for TB. The maternity care training, which was attended by two health workers over six days, was carried out in one of the sites supported by USAID IHP providing clinical coaching on birthing practices. Informants reported that the training focused on delivery assistance for vaginal deliveries, post-delivery care for newborns, including resuscitation, and managing postpartum hemorrhage. The head nurse emphasized that participants were exposed to innovative, lifesaving approaches to delivery assistance. Informants did not indicate whether a debriefing session was held to share the learning from the training with other health workers. Both head nurses noted that health workers participate in “briefings” on a variety of topics on a regular basis.

Supervision

Head nurses indicated that they received monthly supervisory visits from BCZS staff during which supervisors identified problems with health services and ways they could be addressed. In addition, DPS personnel made quarterly visits focused on program themes, such as malaria and TB. The provincial inspection offices might also visit, generally when an offence had been committed. In fact, our evaluation coincided with an IPS visit to the HPHA.

Access to Continuing Education

As was the case during the midline evaluation, informants indicated that the primary way they received information was through training. They might also be exposed to new information during briefings held when health workers who had attended training shared their learning, although these sessions did not appear to be held regularly. Health-related information was also obtained through exchanges during HZ monthly monitoring meetings when health workers presented the status of health services and indicators. Head nurses also mentioned receiving health information on the radio. Access to written materials appeared to be extremely limited, and none of the informants mentioned accessing information on the Internet. Informants underlined a strong desire to increase their knowledge, which they mentioned would improve work capacity. Head nurses specified that they needed to be better informed during or after an event, such as an outbreak (they recounted that after a recent measles outbreak, little information was provided), or after an assessment, such as the endline evaluation..

Attitudes of Health Workers

Informants reported that instances of bad behavior manifested by the health personnel were rare, which was an improvement since the midline evaluation when informants from both HCs described instances of negative behaviors, including health personnel refusing to treat patients or smoking and drinking during work. However, informants from both facilities claimed that the facility receptionist was not welcoming, frequently quarreling with or even insulting sick patients. The CODESA President from the HPHA said:

> *When patients arrive and say they are in pain, the receptionist calls them imbeciles, asking them why they came to the center, what they want him to do, and to leave.*

When negative interactions arose, the patients and/or RECOs were encouraged to share the information with the CODESA President, who tried to intervene quickly by talking to the health provider involved and reassuring the patient that the situation would not occur again. One RECO informant mentioned that they tried to avoid that negative information about the health workers circulating at the community level, which could affect the use of services. If the situation escalated, the CODESA President might request that the head nurse speak with the medical staff involved.

The IT from the HPHA believed that negative behaviors were linked to the work environment, especially poor remuneration and the condition of facilities, adding that none of the health workers in his facility received a salary or risk bonus, and that the only way bad behaviors would stop was by improving work conditions. He considered it ironic that the EU, which insisted that health workers exhibit good behavior and perform well, often did not conform to the agreement made with the HZ. He mentioned that the EU often failed to provide medicines and performance-based payments over several months, while at the same time establishing rules that ensured low service fees and prohibited the purchase of medicines in the local market and the provision of prescriptions to patients, all of which reduced revenue and affected health worker attitudes and behaviors.

The CODESA President from the same HA mentioned that conflict between health workers and patients most often occurred when drug shortages existed and patients were requested to purchase medications. Both ITs reported attending a training on health worker behavior before the midline evaluation.

Health Worker Sources of Motivation

Health worker informants described their main source of motivation as money primarily generated through service provision. They added that the EU was supposed to provide monthly performance-based payments, but payments were consistently late. The IT from the HPHA said:

> *It is the EU that currently supports us in terms of paying service providers. There was a contract that was signed, in the contract it said that before the 15th of the month, the health center workers must be paid. Now we find that when we reach the 15th, service providers are not paid. We go 2, 3, 4, 5 or 6 months without being paid. And yet they require the service providers to work well and provide good results. How can we achieve this?*

The same IT reiterated that the late delivery of drugs negatively impacted HC finances and health worker compensation.

In the HPHC, none of the staff received government salary, and although two workers had previously received risk bonuses, which was 44,000 CF monthly, their names were removed from the list in May 2024. In the LPHC, three of seven health staff, including the IT, were receiving government salary, and the IT was also getting the government bonus. The IT from the LPHA stated that the HC typically generated 500 USD monthly; combined with the EU contribution, which was about 250 USD, monthly revenue amounted to 750 USD, which was divided among seven HC workers. He described the EU contribution as “crumbs,” adding that the HC could generate more funds without IP support, which stipulates reduced consultation fees. Informants reported that other ways health workers obtained compensation were during mass campaigns, efforts to “recover” children who had missed vaccinations, or training, with informants adding that these opportunities were rare.

During the midline evaluation, health workers had been on strike in protest of broken government promises and the lack of salaries. At the time of the endline evaluation, health worker informants stated that they were still struggling to provide for basic family needs. ITs reported that difficult working environments, including the poorly built structure in the HPHA and lack of equipment at both HCs, further demotivated staff. The IT from the HPHA stated that, although the IPs insisted on producing good results, the people central to healthcare were treated poorly, with informants consistently stating that health workers were dissatisfied with their work. The IT from the HPHA said:

> *I am looking for a way to leave, but I don’t know where to go. The day I find an opportunity, I will leave without letting anybody know. I did not study to work under these conditions.*

In addition, ITs suggested that there were no possibilities for professional advancement. Opportunities mentioned to improve work conditions included training to strengthen capacity, with informants saying that training also facilitated opportunities to exchange experiences with other health workers. Recommendations to improve performance included strengthening HC infrastructures and equipment, and paying staff salaries and bonuses. ITs mentioned that health staff got satisfaction from treating patients.

The CODESA President in the LPHA reported that although CHWs played a critical role in the health sector and were eligible to receive PBF payments provided by the EU, the ITs controlled all financial matters, failing to share information on HC revenue or financial support received from IPs. He reported that the IT failed to give CHWs the percentage of money received from the EU as agreed on in the contract. Although he mentioned that as volunteers CODESA work for the advancement of the health sector and country, the Congolese government needed to provide some remuneration to the CHWs to cover basic family needs.

Community Health Services

Infrastructure

Health Areas

Informants described the community health system as composed of CAC committees, CODESA committees, and RECOs. The HZ created CAC committees in 2021 when HA villages elected their members who were trained on their role on the CACs. Since 2021, it appeared that no additional training or material support had been provided to the CACs, which included six CACs in the HPHA and seven CACs in the LPHA. Informants reported that CAC Presidents, who serve as members of the CODESA committee, were responsible for ensuring the collection of monthly health activity reports compiled by the RECOs and sharing other relevant information about community-based health activities or concerns with ITs. In addition, the ITs rely on CODESA members to report key health information to CAC committees, who, in turn, were tasked with sharing this information with community members.

At the time of the endline evaluation, the IT from the HPHA reported that the CACs had reached the end of their three-year mandate and were waiting to hear from territory authorities about the renewal of the CACs. Informants reported that CACs, which were supposed to have at least ten to twelve active RECOs, were comprised of anywhere from one to five RECOs responsible for carrying out household visits and developing monthly community health activity reports. The IT from the LPHA mentioned that the numbers of RECOs on CACs was insufficient to maintain household visits as planned, and the data suggested that the functioning of the CACs had deteriorated since the midline evaluation.

Reported community health services involved in-home visits that CHWs carried out to assess the health status of community members, identify sick patients, particularly children, and refer them to health facilities for further care. They also described participation in occasional campaigns, such as mass distribution of bed nets, vaccinations, or vitamin A. Community actor informants did not talk about international days, which were reported to be held during the midline evaluation.

Regarding other forms of message dissemination, informants mentioned that community radio was not available in the HZ, and although they could sometimes access broadcasts from Mbuji Mayi, health-related messages were rare. When important events occurred, messages were disseminated through village criers or household visits, with CHWs mentioning that they did not have a working megaphone. There was no mention of involving religious leaders in message dissemination, with one RECO recounting that pastors required payment to share messages during church services.

Informants reported mass bed net and vaccination campaigns, with several vaccination campaigns carried out in 2024. They mentioned fewer mini-campaigns, which they recognized were financed by USAID IHP, compared with before the midline evaluation. Informants reported holding mini-campaigns in 2022 and 2023 involving screening for children with malnutrition, identification of children who had missed vaccinations, and

identification of children with diarrhea, although there was no mention of mini-campaigns in 2024. This coincided with reports from government officials at the DPS and HZ levels who said that USAID IHP had not planned mini-campaigns for 2024, and mini-campaigns had slowed in 2023.

Informants reported that facility workers were occasionally involved in community activities, particularly mass campaigns when they acted as supervisors. They might intervene when large groups of community members refused to participate in health events, such as child vaccinations, or if there was a particular health concern, such as a disease outbreak.

Both HAs had previously instituted nutrition groups, which according to informants, had stopped functioning due to the exit of Save the Children, the IP that oversaw nutrition group activities, and the discontinuation of monthly payment to RECOs. Nutrition group activities involved awareness raising about good nutrition, culinary demonstrations of enriched complementary foods, and distribution of porridge for young children in the HCs.

Informants reported that flipcharts focusing on a range of thematic areas were stored at the HCs and occasionally used by facility workers when they led educational sessions, although the materials were old and in poor condition. Some CHWs reported that health workers sold newly obtained flipcharts. CACs did not maintain educational materials for RECOs to use during awareness raising, mentioning that in their villages, they shared messages from memory.

As was the case during the midline evaluation, only the LPHA had a functional iCCM site, which was located 18 kilometers from the HC. The RECO responsible for the iCCM site at the time of the midline evaluation had died and was replaced by a new RECO. The new RECO reported that she had not received formal training but was briefed by the IT on her role. The iCCM site still had a cabinet, basic medicines, such as ACTs and zinc, a register for sick children, kits for rapid malaria testing, a pediatric scale, and referral slips to give to guardians of children referred to the HC. Although during the midline evaluation, the team discovered that the iCCM site experienced frequent stockouts of medications, the RECO reported receiving drugs regularly, which she either collected at the HC or were delivered by a HC worker. Observations of the iCCM register indicated that use was low.

Overall, head nurse informants reported that community activities functioned poorly, with several informants adding that CHWs lacked motivation because they felt poorly treated. There was also the suggestion that community members had become less receptive to the messages shared during household visits, which some informants attributed to difficult living conditions and others associated with a general disillusionment with the health services offered. When describing frustrations the population was facing, the HPHA IT said:

> *Illnesses occur in the community, but because of the partner supplying medicines, there are shortages. The community suffers a lot; when community members arrive at the center with an illness, they find that the center has no medicines. We give prescriptions, and yet the partner said no prescriptions. Community members are losing faith in the health center.*

When talking about the lack of interest in health-related messages, a RECO from the HPHA said:

> *People are living in misery. You go to talk to somebody who needs flour [something to eat], but you give him information, which he does not value.*

This RECO was skeptical about the effectiveness of the messages shared, suggesting that a better approach would be to introduce health messaging to school children.

System Design

Role of CODESA Members

Informants described the role of CODESA members as a bridge between health facilities and the population tasked with ensuring that information was shared between community members and health providers. Consequently, CODESA members collected information from community members about patient care, including complaints about health worker behavior, and shared this information with facility workers, and then returned to the community to report on the health providers' responses. In addition, CODESA members shared health-related messages relayed from the health workers to community members, collected debts from patients treated on credit, and collected monthly CAC reports on health activities. CODESA members were also responsible for monitoring the use of supplies and medicines at health facilities, allowing them to act as the eyes and ears of the community. The CODESA from the HPHA said:

> *I am the representative of the community in the health center. Anybody who wants to send a message to the community must go through me. At the center level, I am busy co-managing all drugs that come in and go out, I must be there to count, to see how drugs are used. I also have the role as community awareness raiser in households during home visits.*

They also played a role in mobilizing the community to take ownership of health activities, including in-facility services, with CODESA informants underlining the important work community members carried out related to HC sanitation and hygiene, which was supported by USAID IHP before the midline evaluation.

In the HZ of Kasansa, CODESA members were elected and trained in 2021. Since the midline evaluation, informants reported that no technical assistance (including training) had been offered to CODESA members, although there were reports of informal briefing sessions about vaccination coverage or how to lead CODESA meetings. The HPHA had a seven-member committee, including two female members who served as treasurer and advisor, whereas the LPHA had a five-member committee, including two female members serving as treasurer and assistant secretary. However, the CODESA President mentioned that only three members were active, and the others only participated when an activity involving money was introduced. The IT from the HPHA mentioned that since he joined in 2013, composition of CODESA committees had become more inclusive of women who he stated often had positions of authority.

Role of RECOs

Informants reported that the primary responsibility of RECOs was to conduct in-home visits to monitor the health status of community members, with a particular focus on children, and to refer sick individuals to the HC for care. RECOs were supposed to report increases in illness episodes to the CODESA President, who subsequently shared the information with the ITs. During household visits, RECOs also delivered messages on key household practices, with several mentioning a focus on hygiene and sanitation, which they attributed to work that USAID IHP had introduced before the midline evaluation. A RECO from the HPHA said:

> *We make home visits, we observe the health of the community, we always provide health education. We share problems in the community with the CODESA President who transmits them to the health center.*

Training offered since the midline evaluation included a session on vaccinations led by GAVI and training on how to organize work and collect and report data, although the sponsor was not mentioned. Most informants reported that the RECOs had not participated in training since 2022. One of the RECOs expressed displeasure about the selection of training participants, suggesting that trainees were chosen according to personal relations rather than merit. RECOs stated that they attended occasional briefings at the HC when new events or activities were introduced, and in turn, were responsible for briefing other RECOs in their CACs, who subsequently shared the information with community members. RECOs emphasized the importance of participating in formal training to increase knowledge and improve skill sets.

Although during the midline evaluation informants reported that RECOs were tasked with visiting 30 households, due to high attrition caused by discontent associated with the lack of remuneration, the number of RECOs had been reduced, forcing the remaining RECOs to serve 30–50 households. There was also mention of RECOs' involvement in select health program activities, specifically TB screening, and awareness raising about birth spacing and the distribution of FP methods that did not require medical interventions. In addition, RECOs mentioned raising awareness about health, hygiene, and sanitation practices; child and maternal nutrition; child vaccinations; the importance of facility delivery; and the main causes of child morbidity and mortality, such as malaria, diarrhea, and pneumonia. Furthermore, RECOs tracked the vaccination status of children in their assigned households and ensured that each child received the appropriate number of vaccinations. At the facility level, the RECOs assisted health providers during prenatal and growth monitoring visits. During outreach visits, they facilitated educational sessions, weighed infants and young children, and helped organize vaccination sessions

The HPHA reported having 30–45 active RECOs, 24 of whom were female. The LPHA had 10–20 active RECOs, with the IT mentioning that the numbers were not sufficient to maintain ongoing activities. Both had a few young RECOs, adding that it was difficult to keep youth engaged. ITs reported that the lack of motivation poses a problem in retaining RECOs, especially since a Food for Peace activity , which had recently closed, had previously offered RECOs some motivation. The CODESA informant from the LPHA mentioned that people agreed to the position because they thought that they would be compensated, but when they realized that no money was involved, they quit. Our RECO informants reported that they were motivated to improve the knowledge of community members and were working out of love for the community. There were no reports of negative behaviors manifested by CHWs, with CHWs reporting that as health representatives, they had to maintain positive relations with community members.

Women participating in focus groups mentioned that community actors taught women about measures to protect their children against illnesses and ensure good dietary intake to prevent malnutrition. It was not clear under what circumstances messages were delivered, with only women from the HPHA referring to household visits, adding that they were not aware of their names and visit their homes infrequently. Other sources of health information mentioned came from women leaders participating in a Food for Peace project responsible for leading monthly group sessions to share information on good nutrition, food safety and hygiene, the importance of ingesting safe water, and the importance of birth spacing. Several women described that their husbands opposed FP, with women from the HPHA stating:

> *My friend is suffering because she has not yet recovered from her previous childbirth, it is men who harm women and children. It is the men who come looking for their wives, and*

if a woman says that she has a small baby, a fight will start right away, but when the child starts reclaiming his/her right, the father will not be there.

During prenatal care, we talk about family planning, but husbands do not accept invitations to participate, he will tell you to tell them [the health workers] that he is not available. If you insist, he will tell you to make the health provider your husband.

Other FGD participants mentioned that conception was solely up to God, with one participant stating, "For me, giving birth is the decision of God and not an effort of men."

In the HPHA, women also mentioned that health information was shared on the radio, adding that radios were controlled by male household members who were primarily interested in listening to news and music, but did not follow health messaging. One woman from the HPHA said:

Men do not listen to the programs on the radio or television related to health, they only listen to music and what is going on with the war in the East or what the President is doing. Often, they take their radios to listen with their friends.

Specific Services Offered

Bed Net Distribution

Informants reported that bed nets were provided to women during their first prenatal visit and when children received the measles vaccination at nine months, and in the LPHA to women giving birth at the facility's maternity ward. At the time of the endline evaluation, both HCs had stocks of bed nets. When stockouts occurred, informants reported that the BCZS generally had adequate stocks to respond to HC needs.

The most recent mass distribution of bed nets occurred in 2023. When mass campaigns did happen, HC leadership might oversee distribution; however, recently people from outside the HA have been used for on the ground distribution. As was the case during the midline evaluation, informants reported that poverty interfered with the proper use of bed nets. CHWs mentioned that many community members used bed nets to soften the sleeping area of small children, who often sleep on the hard ground, or that many households did not have adequate space to hang the net. Even when nets were used, some informants mentioned that people did not hang the net properly, allowing mosquitos to enter under the net. Some people used the mosquito nets for other purposes, such as a fishing net, a yard fence, or to cover vegetable produce in gardens.

Women in the focus groups confirmed that bed nets were distributed during ANC visits and after facility deliveries, and in the HPHA, women also mentioned during CPS sessions. They admitted that use of bed nets varied, with some villagers using bed nets as a blanket or to sleep on. A woman from the HPHA said: "I received three mosquito nets, the children sleep on one and I use the other as a cover, and I use the last one to sleep on." A similar response was elicited from a woman from the LPHA, who stated: "I make my children sleep under mosquito nets, but there are others who make their children sleep on mosquito nets. You spread the net, and the children sleep on top or use it as a cover." One woman who only owned one bed net she received during an ANC visit expressed confusion whether she or her child should be prioritized to use the bed net.

Vaccinations

Informants in the HPHA reported that vaccinations were provided during CPS according to the child's vaccine calendar, whereas in the LPHA we learned that vaccines were administered once monthly as well as during

community outreach in distant villages. Vaccination campaigns were also carried out periodically, with informants reporting a polio campaign a month before the evaluation, as well as plans for another polio campaign in August and a measles campaign in September. Community announcements about the timing of vaccinations were made before campaign events.

Although both HCs had solar powered refrigerators to store vaccines, informants reported that they occasionally lacked power during the rainy season. Informants mentioned that vaccines were replenished monthly by the stock maintained in the BCZS, although both BCG and OPV vaccines were out of stock at the time of the endline evaluation. As reported during the midline evaluation, stockouts of the BCG vaccine posed an ongoing problem, with some informants mentioning a recent three-month shortage of BCG. They also experienced occasional stockouts of other vaccines, but which lasted for shorter periods. When vaccines were replenished, mini-campaigns were carried out to inform community members about their availability and eligible children were called to the HCs. Other challenges mentioned included community concerns that vaccines caused illness in children, manifested by swelling at the injection site, fever, and inconsolable crying. Informants reported that mothers still believed that the vaccine cycle was completed at nine months, and it was hard to convince mothers to return to the HC for additional vaccinations when the child reached 15 months, with guardians maintaining that the child was too old to be vaccinated.

Mothers and grandmothers of young children stated that children received vaccinations at the HC, with women from the LPHA reporting that child vaccinations were offered monthly. Women from the HPHA indicated that some community members were affiliated with churches that opposed both vaccinations and biomedical healthcare. Participants in the LPHA reported occasional mass vaccination campaigns offering OPV, measles, or tetanus vaccines.

Informants from the HPHA mentioned that they organized 12 vaccination sessions per year, including 8 sessions at the HC, and 4 outreach sessions, whereas informants from the LPHA reported that they organized only 7 sessions the previous year, including 4 sessions at the HC and 3 outreach sessions in remote villages. All respondents agreed that children between 0 and 9 months were eligible for vaccines.

VIVA Approach

Informants reported that there had not been any VIVA activities in the HZ of Kasansa.

Community Health Worker Motivation

CHWs reported that they agreed to work as volunteers out of concern for their community members who lacked information to ensure that their family members maintained good health. They indicated that they felt honored that community members had entrusted them to work as CHWs and were committed to serving their community members and improving the health situation in their villages. The CODESA President from the HPHA said:

> *I want to see that my population is healthy, for the community to develop. And also, to accomplish the task given to me by people. When people place their trust in you, you have to work to maintain it. We aim to do better in what we are called to do.*

They added that they performed their job to help their community and country, and were motivated to ensure that community members understood the importance of facility care and to improve health service use, especially for children. Several informants alluded to other RECOs who abandoned the work due to lack of

compensation, with one CHW mentioning that teachers often became RECOs but later become disillusioned by the lack of salary, even poking fun at the CHWs for working for the poor. Some added that other community members believed that the CHWs were compensated for their work.

Community actors mentioned that they occasionally had opportunities to participate in special events, such as campaigns, when a small compensation (5 to 15 USD) might be offered, although sometimes promised financial rewards were not given. Training also involved financial compensation, although since the midline evaluation, none of the CHW informants had participated in a training offered by USAID IHP. Although the CHWs recognized that they had agreed to work as volunteers, all our informants reported that some financial support would motivate them to dedicate more time to community-based health interventions. Informants also reported that they needed more capacity strengthening to increase their knowledge and the quality of their work, underlining that training opportunities were rare.

Discussion

This section presents a synthesis and interpretation of the quantitative and qualitative results and their implications, organized by evaluation question. It also presents the limitations of the evaluation.

Evaluation Question 1: Did the expected changes in outcomes and impacts occur?

Objective 1: Strengthen Health Systems, Governance, and Leadership at Provincial, Health Zone, and Facility Levels in Target Health Zones

Infrastructure

From 2019 to 2024, USAID IHP provided modems and financed Internet connectivity through satellite or cellular data at the DPS and HZ offices. Consequently, in the 2019/2024 panel, a significant increase was observed in the number of HZ offices with access to the Internet, and strong performance was indicated at endline. Similarly, the proportion of HZ offices with access to electricity significantly increased, although electrical infrastructure was not a focus of USAID IHP investment.

However, despite these improvements, there was virtually no change in offices reporting at least eight hours of electricity available per day, and the number of facilities reporting at least eight hours of Internet connectivity remained low in 2024. The lack of reliable communication infrastructure likely affected other performance metrics, such as the observed mid-poor performance of communication between HZ offices and the lack of significant changes in the timeliness of MAPEPI submissions. Future programs may consider focusing on the maintenance and reliability of the infrastructural improvements made by USAID IHP.

PICAL Assessments and Annual Operations Plans

Starting in 2019, USAID introduced the PICAL tool at both the DPS and select HZ offices to strengthen the capacity of participating bodies in management and governance. Although the PICAL tool is designed to track improvements through consecutive assessments, many HZ offices only participated in a single PICAL assessment. Although the performance indicator for PICAL assessments demonstrated “poor” performance, it should be noted that only 45 HZs were targeted for PICAL assessments by USAID IHP. More attention should be drawn to the significant increase in uptake of the PICAL tool across the course of the project.

A significant focus of USAID IHP intervention was the creation and validation of annual operations plans (PAOs) across all tiers of the health pyramid. By 2019, the program reported that all HZs and provincial health offices had PAOs in place. Although the health facility surveys did not directly assess the prevalence of PAOs at either the HZ office or health facility level, these plans would be expected to improve operational capacity to conduct routine activities.

Supervision

USAID IHP provided financial, material, and technical assistance for supportive supervision at all levels of the health system over the course of the program. Correspondingly, the supervision of HZ offices by provincial and national actors demonstrated strong and improving performance throughout the program. In sharp contrast, the supervision of hospitals and HCs saw a significant decline in the regularity of supervision visits. In some cases, such as in Tanganika and Sud Kivu, routine supervision was made difficult by regional insecurity. However, by 2024, no province had achieved a greater than 50 percent monthly supervision rate of either hospitals or HCs as seen in the endline health facility survey.

In general, HCs appeared to have been more routinely supervised than hospitals. Much of the decline in health

facility supervision occurred between the 2021 and 2024 evaluations, coinciding with the transfer of some supervision responsibilities from USAID IHP to the provincial health departments, including the mobilization of financial resources. In addition, in 2022, the program scaled back support for some supervision activities in favor of prioritizing essential activities, relying on local partners for integrated supervision.

Health workers reported in qualitative interviews that supervision was critical to improving health services, and that the reduction in supervision visits negatively impacted the quality of health services delivery. The reason cited for the lack of supervision visits were insufficient funding or delayed funds disbursements. Furthermore, key informants indicated that the lack of ownership of supervision visits by provincial authorities prevented the handover of supervision activities from USAID IHP to provincial actors following the reduction in financial support for routine activities. In particular, the widespread implementation of PAOs did not seem to maintain adequate levels of health facility supervision when USAID IHP support was withdrawn. Given the important role of supervision visits in ensuring the quality of health services, future programs should consider exploring additional mechanisms to finance supervision of health facilities as well as increase ownership of health system components by provincial and national actors, alongside training and capacity building for supervisors.

Communication and Coordination

USAID IHP supported increased communication and coordination among the levels of health management through support for meetings and training sessions at national, provincial, and operational levels. The provincial health offices indicated high levels of attendance at technical meetings. Likewise, HZ offices showed strong participation in the COGE provincial meetings, likely enabling and contributing to the improved supervision visits of HZ offices. However, HZ offices did not appear to communicate regularly with other HZ offices despite the enabling factors of increased access to electricity, cellular connectivity, and the Internet.

Strengthening of CODESAs

A key strategy to improve local governance for USAID IHP was capacity building of CODESAs and CACs. Support for CODESAs included training, technical assistance, and financing for CODESA activities, such as meetings and transportation. From a governance perspective, this approach appeared successful: HZ offices' communication with CODESAs remained strong throughout the program, and significant improvements were made in the involvement of CODESAs in health facility management, awareness of community scorecards, and participation of health facilities in CODESA orientation. Taken together, these indicators demonstrated a revitalization of CODESA bodies in the co-management of local health delivery in areas that received USAID IHP support.

Community scorecards were one approach implemented by USAID IHP for CODESAs and CSOs to monitor health facilities and request improvements. Activities promoting the training and use of community scorecards were not initiated until 2021 and appeared to have limited reach. As a result, the implementation of community scorecards by CODESAs significantly decreased between 2021 and 2024. By 2024, fewer than one third of CODESA members indicated they had participated in community scorecard activities in the past 12 months. Qualitative data suggested that the financial support and training for community scorecards were delayed and often insufficient to enable successful adoption of the approach. Take together, the evaluation data indicated that further work is needed to ensure that the community scorecard approach is sustainable.

A significant drawback of the CODESA/CSO strengthening efforts appeared to be their patchwork implementation. The 2021 and 2024 health facility surveys indicated no CODESA participation in either community scorecards or access to and use of patient feedback forms in Sankuru. The overall effectiveness of the CODESA co-management may have been hampered by inconsistencies in implementation across program areas.

Health Workforce Capacity Building

USAID IHP worked to improve human resources for health by organizing workshops at the provincial level, supporting the development of human resource registers, and providing both technical and financial support for the rollout of the iHRIS software. The program placed significant emphasis on gender equity and women's empowerment activities through the establishment of gender units. Perhaps consequently, health workers job satisfaction increased over the course of the program, with a greater increase in job satisfaction observed among female health workers than male health workers.

The number of workers who had ever received training in health information systems increased significantly over the course of the program, although the percentage remained low (< 20%) across all provinces. Furthermore, health information system training did not appear to be institutionalized because the number of health workers having received training in the previous 12 months declined significantly across the 2019/2024 panel health facilities. Future programmatic efforts may consider the institutionalization of training activities, such that health workers are routinely retrained on health information systems.

Objective 2: Increase Access to Quality, Integrated Health Services in Target Health Zones

Equipment

From 2021 to 2023, USAID IHP distributed basic consultation materials, vaccine cold chain equipment, surgical equipment, maternity and hospital beds, and laboratory equipment to hospitals and HCs. Correspondingly, the percentage of HCs that had all basic equipment increased significantly between 2019 and 2024. Significant increases were also noted in facilities with baby and delivery tables, ultrasounds, and masks and eye protection, which was likely due to the COVID-19 response.

USAID IHP emphasized monitoring the use of equipment during supervision visits which, if sustained, could help ensure its proper use going forward. The prevalence of maintenance technicians at health facilities increased—a key factor in the longevity of the equipment. However, we did not find evidence that USAID IHP worked to establish a sustainable system of equipment replacement. Coupled with the lack of emphasis on financing schemes that could be used to raise funds for equipment (discussed later in this section), the health system remains largely reliant on donor funding for medical equipment.

Drugs

USAID IHP provided drugs to health facilities that informants considered high quality and helpful for facilities to avoid purchasing drugs from the private market. However, the number of drugs that USAID IHP procured decreased sharply over the course of the program. Operational problems, such as late ordering and underuse of the medication management system, coupled with irregular, often insufficient deliveries of drugs led to regular stockouts, especially of malaria medications and antibiotics. Despite these challenges, the survey data showed that drug availability improved between 2019 and 2024. There was no change in the percentage of facilities with all tracer drugs in stock on the day of the survey, but HCs saw significant increases in the stock of

oxytocin, artesunate-amodiaquine, amoxycillin, oral rehydration salts, Depo Provera, and implants. Only one drug showed a significant decrease between 2019 and 2024: rifampicin and isoniazid in hospitals. The 2021/2024 panel showed significant decreases for several drugs, possibly reflecting USAID IHP's reductions in support. Future programs could build on USAID IHP's foundation by focusing on the operational issues both within the health system and, if USAID chooses to provide drugs directly, in the delivery system. Furthermore, changes in the drugs that a program provides should be coordinated well in advance to ensure that the government is prepared to take it over.

Service Availability

Service availability appeared to improve over the course of USAID IHP. Significant increases were observed in the percentage of HCs offering the full minimum package of preventive services, the minimum package of curative services, and comprehensive services for SGBV. Services falling under each of the focal areas are discussed below.

- **FP:** Overall, the FP approach appeared to be effective at increasing the availability of services. The impact evaluation found a significant program impact on new acceptors of modern contraceptive methods; in fact, this was the largest magnitude program impact detected in that evaluation (Data for Impact, 2024).

USAID IHP's approach was to train facility-based health workers in the provision of FP. Correspondingly, there were significant increases in the percentage of facilities that offered FP for pregnant women, offered long-acting or permanent methods of FP, and that had FP messages specific to youth. Health facilities' capability to insert and remove IUDs and implants also increased significantly. Improvements in adherence to national guidelines likewise increased. At HCs, the percentage of HC-based workers who said that they would offer a method to a young, married, unaccompanied woman with no children increased significantly between 2019 and 2024.

USAID IHP supported RECOs to conduct outreach in communities, including mini-campaigns, and used nursing students to administer contraception. USAID IHP also provided some FP commodities. Although informants reported that stockouts occurred, overall, increases in the stock of Depo Provera and implants increased over the course of the program.

- **Immunization:** USAID IHP supported the MOH's immunization strategy, focusing on using RECOs to identify and refer children for vaccinations. Support was also provided for maintaining the cold chain, conducting supervisory visits, and holding quarterly and annual vaccination program meetings. USAID IHP also supported the rollout of the COVID-19 vaccine. USAID IHP faced challenges in reaching remote areas and with stockouts of the BCG vaccine, which was supplied by the government rather than the program. Informants also reported that USAID IHP support dropped off in some HZs over the course of the program.

Facility survey data showed that the percentage of facilities offering vaccination services was already high and remained high through 2024. The stock rates of all vaccines assessed increased significantly between 2019 and 2024, with BCG being the most likely to be out-of-stock. The impact evaluation detected a small but significant positive impact on the rate of measles vaccination in children under five compared with comparison areas that were not supported by USAID IHP.

- **Malaria:** USAID also trained facility-based health workers in the detection and treatment of malaria. In addition, the program provided malaria medications, rapid tests, and bed nets, and supported

supervisory visits to health facilities and malaria review meetings.

Informants reported a reduction in malaria cases, which they attributed to the ongoing availability of anti-malaria drugs, tests, and bed nets. The impact evaluation reflected this, with cases of severe malaria treated at health facilities decreasing significantly in USAID IHP-supported areas compared with the comparison areas. The facility survey data showed significant increases in facility-based bed net distribution and artesunate-amodiaquine stock. Malaria screening and malaria microscopy were already prevalent in 2019 and remained prevalent through 2024. Concerningly, the percentage of HCs offering IPT decreased over the course of the program. The reason for this change is unclear.

- **MCH:** USAID IHP supplied necessary equipment to support the safe management of labor and maternal care. Correspondingly, the facility survey showed significant increases in the prevalence of newborn tables, delivery tables, ultrasound machines, and improved stock rates of oxytocin and folic acid.

USAID IHP trained health workers in the safe management of labor and contributed to the establishment of obstetric centers of excellence. The program introduced clinical mentoring to improve delivery practices and newborn care, and supported maternal health committees. The facility survey showed that the prevalence of prenatal and postnatal counseling was already high, and the percentage of facilities equipped for normal deliveries increased to a very high level. Although the percentage of HCs offering all seven services for pregnant women was significantly higher in 2024 compared with 2019, the overall percentage remained low at 16 percent.

Maternal health committees were supported to conduct audits following maternal deaths, with the aim of improving outcomes and accountability in maternal care. Informants reported that participation declined as external support tapered off. The medial record review found that maternal survival and child death rates at hospitals improved between 2019 and 2024, and complication rates decreased. C-sections at HCs increased, and active management of the third stage of labor also saw slight improvement. Syphilis testing increased significantly, along with a smaller increase in HIV testing. Blood pressure testing increased slightly, and diagnosing dysentery in a clinical vignette saw a significant increase. The impact evaluation did not detect program impacts on any of the MCH indicators; however, for each indicator, the trend moved in the desired direction between 2019 and 2024.

- **Nutrition:** USAID IHP's nutrition efforts largely began in 2022. The program trained health workers in the prevention and treatment of malnutrition. The program focused on supporting community-based IYCF nutrition groups and revived CPS consultations for growth monitoring. With Ukraine supplementary funds, the program also supported local NGOs to improve food production and economic growth through small animal raising and providing materials to women farmers.

The facility survey did not detect much change in nutrition-related indicators. The percentage of facilities offering nutrition planning for pregnant women, dietary counseling for breastfeeding, and the percentage offering growth monitoring and promotion for children were low and unchanged over the course of the program. The impact evaluation showed that rates of moderate malnutrition in children under five were not impacted by the program, and in fact, increased in both USAID IHP-supported areas and comparison areas between 2019 and 2024.

- **TB:** USAID IHP supported TB activities by contracting community-based organizations to conduct door-to-door case identification and to transport samples. In addition, RECOs were used to detect and refer TB

cases, and nutritional support was provided for multi-resistant TB patients. The program supplied TB drugs and financed supervision to ensure medication adherence. At health facilities, USAID IHP trained health workers and provided diagnostic equipment, such as microscopes.

The facility survey did not detect any changes in the percentage of health facilities offering TB screening or treatment, and the stock rate of rifampicin and isoniazid also did not change. However, based on USAID IHP's activities, which were focused on community-based case detection and treatment, one might not expect those indicators to have been impacted. Unfortunately, the impact evaluation did not include TB cases due to limitations in data availability.

- **WASH:** The program initially supported WASH activities related to water access and biomedical waste management at health facilities, but these interventions were discontinued in 2022 due to budget constraints. The facility survey found that the percentage of facilities offering counseling on mother and child hygiene decreased significantly between 2019 and 2024. The prevalence of sanitary toilets at health facilities did not change.
- **Service integration:** USAID IHP was conceived as an "integrated health program." Three examples of USAID IHP promoting service integration were identified. First, in general, the integrated package of services offered. Second, the program promoted the IMCI protocols on the integration of curative and preventive care. Last, USAID IHP worked to integrate COVID-19 vaccine activities in routine health services.

Health Worker Staffing, Support, and Accountability

The facility survey showed that the percentage of facilities with adequate numbers of nurses increased significantly between 2019 and 2024, as did the percentage with an adequate number of maintenance technicians. However, across the board, staffing levels at health facilities remained extremely low. This was echoed in the qualitative data, in which informants discussed high turnover, low remuneration, and low motivation as challenges in the implementation of the program.

Health workers reported that the provision of equipment, supplies, and medications by USAID IHP positively impacted their job satisfaction. Supervision, mentoring, and counseling were important, as was interfacing with community representatives. However, competition with traditional healers was discouraging.

In the interviews, health workers expressed a desire for more training focused on improving health worker attitudes and behaviors. In fact, USAID IHP developed a specific training approach to enhance interpersonal skills, with an emphasis on empathy, and this training was conducted across target provinces. The facility survey showed notable improvements in health workers' attitudes between 2019 and 2024, with more acknowledging patients' education and showing appreciation for their efforts. In addition, fewer health workers believed that patients consistently made poor health decisions despite their advice. However, there was a slight increase in the belief that patients often treated health workers without respect, making it difficult for them to reciprocate respect. There was also an increase in health workers who felt less concerned about patients' clinic experiences, and who viewed their role as primarily diagnosing and treating, rather than educating. In some provinces, fewer health workers focused on addressing all a patient's health needs, instead prioritizing immediate concerns.

Health workers' remuneration remained low over the course of the program, and participation in training did not correspond to salary increases, which was discouraging. In some areas, PBF was implemented, but its

impact was limited by overall low remuneration.

To promote accountability, community members were encouraged to report health workers' inappropriate behavior through a greenline. Although the facility survey did not include data on the greenlines, it did find that rates of verbal and physical abuse of health workers by patients and their families did not change over the course of the program, suggesting that this mechanism may not yet be widely known or accepted.

Improved Affordability of Integrated Health Services

Although USAID IHP initially proposed different financing approaches, like results-based financing, they were later dropped. The program did, however, work with provincial administrations to invest mining royalties in health infrastructure and essential equipment.

Health workers reported that they continued to treat patients on credit, allowing patients to receive care even if they could not pay upfront. However, debt incurred by community members was a common issue. The facility survey showed that financial practices that inhibited access were on the rise. In 2024, significantly more facilities refused services to an emergency or labor and delivery patient who could not pay, and significantly more would treat the patient but refuse to discharge them until they paid. Furthermore, fee transparency decreased, with significantly fewer posting their fee schedules for patients to see.

Increased Availability of Quality, Integrated Community-Based Health Services

USAID IHP supported the revival of CODESA and CAC committees and the training of RECOs. The VIVA interventions were scaled up, and community scorecards were implemented to involve community members in healthcare management. USAID IHP also established contractual agreements with community organizations to lead community-level activities, such as TB case detection.

RECOs were involved in various community-based activities, including FP initiatives, mini-campaigns, and providing contraceptive methods through nursing students. Although a facility survey did not show a change in the number of RECOs engaged in community-based distribution, these data were only collected in 2021 and 2024. RECOs also identified children with missed immunization doses, contributing to the immunization efforts.

For malaria and nutrition, the program set up 288 iCCM sites across the province using dedicated funds. In addition, the nutrition program focused on establishing nutrition (IYCF) groups, conducting culinary demonstrations, promoting gardening and small animal husbandry, distributing seeds for planting crops, and promoting income-generating activities.

Objective 3: Increase the Adoption of Healthy Behaviors, including the Use of Health Services in Target Health Zones

Community Health Workers

Key and in-depth informants stressed the important role that community activities have in raising community awareness about health themes and improving service use. However, the qualitative endline evaluation points to a decline in the functionality of community health systems, which appeared to be facing greater difficulties retaining volunteer health workers. The change is likely related to the fact that more IPs were providing incentives to CHWs engaged in specific activities, but once discontinued, the CHWs frequently lost motivation or abandoned the work. Constant turnover of CHWs impacts the work quality because CHWs are

replaced by people who lack training and adequate understanding of key health themes.

Although the provision of financial incentives may not be possible, CHWs could benefit from other support, such as more training and support materials, including educational aides to carry out their work, as well as supervisory visits and coaching by BCZS and DPS officials. When activities involving financial incentives occur, such as CHW participation in campaigns, mechanisms should be established to ensure that CHWs are paid in a timely fashion and as promised.

CAC and CODESA Committees

USAID IHP has contributed to the revitalization of CAC and CODESA committees, which according to the midline and endline evaluations, has provided important structure to the organization and conduct of community activities. However, at the time of the endline evaluation, many committees were at the end of their three-year mandates, and it was not clear how subsequent elections would be supported and when elections would take place. Once again, there is little sign of government ownership needed to ensure continued oversight and support of these community structures.

VIVA Campaign

There was no sign of the uptake of VIVA interventions, which according to the qualitative endline evaluation, is receiving minimal attention and oversight by government workers. During the qualitative endline evaluation, there was virtually no mention by community members living in VIVA target health areas of radio messages associated with the VIVA approach.

Mini-Campaigns

Qualitative endline informants reported that mini-campaigns were an effective way to increase healthcare use and boost health indicators, at least temporarily. The qualitative midline and endline evaluations showed that mini-campaigns often needed better preparation and organization to ensure that adequate medications and commodities were available to those community members responding to encouragement to seek health services. It is not clear whether government workers will have the capacity and resources to sustain implementation of mini-campaigns once USAID IHP is discontinued.

Local Organizations

USAID IHP's approach to establish contracts with local NGOs to lead community activities is an important initiative that will better ensure sustainability over the long term. However, the qualitative research identified some deficiencies in the work of the contracted NGOs, underlining the need for USAID IHP to increase monitoring and oversight of the contracted NGO activities.

Mobilization of Activities Supported by Supplemental Funds

Activities associated with the supplementary Ukraine funds are way behind schedule, with few activities underway. These delays have resulted in the missed opportunity to support farmers during two planting seasons. In addition, at the time of the endline evaluation, domestic animals had not been distributed. It is imperative that USAID IHP and their collaborating partners develop strategies to ensure that adequate capacity building of beneficiaries and distribution of essential commodities, such as seeds, are available to target farmers in a timely manner.

Community Health Data

In the future, it will be important to include community health activities in the DHIS2 and ensure the quality of

those data. This will allow evidence-informed management and funding of those activities and rigorous assessment of their effectiveness.

Evaluation Question 2: If there were changes in healthy behaviors over the course of the study period, to what extent were these attributable to USAID IHP?

This evaluation as addressed quantitatively in the impact evaluation (Data for Impact, 2024). Overall, mostly small changes were observed in the RHIS indicators assessed seven years into USAID IHP program implementation. The year 7 impact evaluation results showed that 11 of 13 indicators had moved in the desired direction, with five of those 11 indicators exhibiting significant differences between IHP intervention facilities and comparison facilities when adjusting for multiple hypothesis testing, suggesting that USAID IHP significantly impacted those indicators. Of the significant indicators, the largest magnitude of impact was observed for new acceptors of modern methods of contraception, which may partly reflect the more diverse cadre of workers introducing methods identified during the qualitative research. Small impacts were observed in the provision of insecticide-treated bed nets at ANC visits, treatment of complicated diarrhea/dehydration, and measles vaccinations. The qualitative data identified potentially important information that could be used to further boost these indicators, such as the need to better inform caregivers that a second measles vaccine is offered at 15 months and increased investments in outreach visits to distant villages.

Overall, the results highlight areas that may require additional focus in future programs, such as the treatment of complicated malaria and the prevention of malnutrition in children. The difference in differences estimates for both indicators suggested movement in an undesired direction when comparing intervention sites with comparison sites (i.e., more instances of moderate acute malnutrition and fewer instances of complicated malaria treatment). Notably, the treatment of complicated malaria was significant based on both unadjusted and adjusted p-values. Further investigation may be warranted to contextualize whether these results were due to better treatment preventing the incidence of complicated malaria and malnutrition cases, or a lack of treatment of cases in IHP-supported HZs.

Evaluation Question 3: Did the program contribute to gender equity in health services and within the health system?

The USAID IHP program supported the creation of gender units in all DPS offices and in select BCZS to address gender-related issues. These committees were established to train staff in overseeing the implementation of gender-sensitive approaches in the health system. These meetings and training sessions focused on such topics as gender-based violence, positive masculinity, gender integration, supervision of health facilities, dissemination of the new National Strategy to Combat Gender-Based Violence, and identifying connections between gender norms and health. Facility-based health workers also received training in gender. In interviews, HZs stated that they had not conducted audits to assess gender sensitive approaches at health facilities, and suggested that more awareness raising was needed, especially at the community level.

Unfortunately, USAID IHP's endline household survey had not been conducted at the time of this evaluation, so data on individual-level gender-based inequities could not be included.

Regarding gender equity among health workers, the program encouraged the promotion of female RECOs and emphasized that CACs should be comprised of at least 30 percent women. In the interviews, informants indicated that in 2024, more than 40 percent of CACs were led by women, indicating progress in promoting female leadership at the community level. The facility survey found that the number of male and female

nurses at hospitals was roughly equal, but that at HCs and in other positions (with the exception of midwives), there were fewer women.

The percentage of HC workers reporting general job satisfaction increased significantly between 2019 and 2024, with female health workers seeing a more pronounced increase in satisfaction. In terms of training, health workers were less likely to be recently trained in health management information systems compared with males but did not experience the same decreases in training between 2019 and 2024 that males did. Female health workers were trained in the iHRIS at similar rates as their male counterparts.

Evaluation Question 4: What factors enabled or limited the success of USAID IHP?

The major factors that facilitated the success of USAID IHP were:

- **Focus on laying a solid foundation of leadership and governance to support service delivery:** The midline evaluation primarily detected improvements in leadership and governance, which the endline evaluation showed were followed by improvements in service delivery by the end of the project.
- **Components of health system strengthening:** Much of the project was focused on health system support activities, such as training and the provision of equipment and medications. There were also strong components of health system strengthening, such as the establishment of gender units and clinical mentoring systems.
- **Additional funding:** After the budget cuts, additional funding was acquired from USAID programs, supplemental Ukraine funds, and mining royalties.

The major external factors that limited the success of USAID IHP were:

- **TIPS sanctions:** USAID IHP had to shift its focus from government to nongovernment actors due to TIP sanctions, but these sanctions were later lifted, allowing the program to continue its planned activities.
- **COVID-19:** The pandemic impacted USAID IHP staff's ability to travel to project sites, necessitating virtual work. Project activities also shifted to the COVID-19 response.
- **Nurses' strike:** A health worker strike that began in June 2021 significantly disrupted USAID IHP activities, leading to reduced service delivery and incomplete data reporting in several provinces.
- **Disengagement by the MOH:** The MOH's lack of appropriation of routine activities and poor maintenance of drug stocks were major challenges for the health system, exacerbated by decreased essential drug provision from USAID.
- **Insufficient national health budget:** The national health budget remained low at 5–7 percent of the national budget, leading to underpaid and undermotivated health workers despite increased risk bonuses and efforts to centralize recruitment.
- **Health worker turnover:** The project struggled with ongoing turnover of health personnel, which has been primarily driven by political affiliation and connections. Frequent turnover makes training less efficient.

The major internal factors that limited the success of USAID IHP were:

- **Project budget cuts:** USAID IHP faced budget cuts starting in 2022, reducing its total funding from 314 million USD to 243 million USD, leading to the discontinuation of WASH activities, staff reductions,

and office closures, while shifting the focus to providing technical assistance to the MOH and reducing direct activity implementation.

- **High rates of health worker turnover:** USAID IHP faced significant challenges due to high turnover among senior-level staff, including key positions vacated and subsequently filled throughout the project.

USAID and the project made several strategic decisions that limited the project's ability to meet its goals. The main decisions were:

- **Limited investment in health facility rehabilitation.** Poor quality facilities impact patient care and health worker satisfaction.
- **Limited investment in connectivity (electricity, Internet, etc.) at the health facility level:** Lack of electricity affects the scope of services that can be provided, quality of care, and health worker satisfaction. A lack of telephone and Internet connectivity limits remote supervision, data reporting, communication about referrals, and opportunities for health workers to obtain new guidelines and access information.
- **Decrease in the number of drugs that USAID supplied:** Informants cited this decision as a reason for stockouts of medications.
- **Lack of focus on financing schemes for patient care:** Although the project helped secure funds from mining, little was done to affect user fees. This may have impacted use rates and the incidence of catastrophic health expenditures.

Limitations

The analyses presented in this report have several limitations. Although the closed panel design minimizes the impact of confounding variables, the surveys were conducted at different times of year. In this report, we did not control for the potential effects of seasonality.

Moreover, because the baseline survey was conducted in only six of the nine USAID IHP-supported provinces, many of the findings presented here are not fully representative of the program.Qualitative data were not collected in all provinces supported, which may limit the generalizability of those findings.

Midline survey data were collected during the COVID-19 pandemic (April and May 2021). Although case rates appear to have been low in most USAID IHP-supported areas, we cannot rule out an impact on indicators of health system functioning during this time.

Last, because the endline household survey[5] had not been conducted at the time of this evaluation, we were unable to assess change in quantitative indicators related to healthy behaviors.

[5] The endline household data are expected to be available in 2025.

Recommendations

We offer recommendations for maintaining the successes of USAID IHP and further improving the approach should USAID decide to continue it in future programming. These recommendations are organized by objective. Overall, we found that there were clear synergies among the three program objectives and they would form a good basis for future programs.

We also suggest areas that were not emphasized in USAID IHP that could be considered for future investments in strengthening the DRC health system.

USAID IHP approach

Objective 1: Strengthen Health Systems, Governance, and Leadership at Provincial, Health Zone, and Facility Levels in Target Health Zones

1. The PICAL tool has been gradually adopted across HZs, with a quarter of the HZs participating in at least a single PICAL assessment by the end of the project**. Emphasis should be placed on how to use the PICAL results to guide management changes in HZs.**
2. The supervision of HZ offices by the provincial offices increased between 2019 and 2024. However, the frequency and consistency of supervision visits at the operational level remain a key challenge. Both hospitals and HCs received significantly decreased numbers of supervision visits over the course of the project. **Future work should consider mechanisms to encourage more frequent supportive supervision visits at the operational level. In particular, the MOH and partners should make available the necessary means for routine supervision of health facilities by zonal supervisors across all targeted provinces.**
3. Provincial health offices and HZ offices regularly participated in managerial and technical meetings, including data monitoring meetings. Every HZ office surveyed at the endline sent a representative to provincial management meetings (COGE). In interviews, participants considered these meetings to be critical venues to share information and learn from each other's experiences. **These meetings should continue to be supported, ideally by the MOH, but otherwise, by USAID.**
4. Community-engaged management of health facilities improved through CODESA and community scorecards mechanisms. Although awareness of the community scorecard program increased substantially, quantitative data indicated a more active role of the CODESAs in the management of health facilities than community scorecards**. Further work is needed to assimilate the community scorecard approach in routine management decisions.**
5. USAID IHP invested tremendous resources in high-quality technical training. However, due to the vast number of targeted facilities, only a fraction of health workers benefitted from formal training sessions. In addition, health workers raised many concerns about the selection of training participants, which is determined by government health officials. Although trained health workers were expected to share information acquired during the training with other health workers, the transfer of information through "briefings" was not happening as planned. The cascade training approach was likely diluting the quality of information obtained during training sessions. **The program needs to evaluate how to improve the training approach and process of selecting trainees.**

6. Health workers, especially in rural areas, had little access to updated health-related information. USAID IHP may consider investing in formal mechanisms to disseminate updated health-related information to health workers at the operational level, such as Internet sites, cellular messaging, or monthly bulletins shared at routine meetings. **USAID should consider setting up other mechanisms designed to ensure that health workers in more remote areas and CHWs can access updated health information.**
7. Support provided to the IPS and the installation of greenlines was considered one of the major successes of USAID IHP. However, the qualitative endline evaluation identified many limitations in the approach, including that several telephone lines may be installed in the same facility, community members were unaware of the purpose of the greenlines, and telephone numbers were often not posted in places where they were visible, all of which interfered with the intended use. In addition, funds allocated to the IPS were not sufficient for workers to carry out routine visits and audits as needed. The qualitative endline data showed that sanctions or suspensions of higher-level officials convicted of corrupt practices were often lifted shortly after the conviction. **Accountability mechanisms should be more widely publicized, and USAID and the MOH should ensure that that action is taken on credible reports.**

Objective 2: Increase Access to Quality, Integrated Health Services in Target Health Zones

8. The availability of many services increased, as did equipment availability at HCs. There was high coverage of basic services, but disease-specific service availability was mixed. FP service availability improved and was high. Comprehensive SGBV service availability improved but was still low. TB testing and treatment were low and did not change. **Targeted efforts focused on low-prevalence services is needed; this may involve training, equipment, and community outreach.**
9. The essential equipment provided by USAID IHP contributed to the quality of health services. However, some equipment could not be used due to lack of electricity, inadequate space in the facility, or because health workers lacked adequate training. **USAID should continue to support training to ensure that more sophisticated equipment can be used properly.**
10. Drug shortages continued to be a major problem. The InfoMED software, designed to monitor drug usage and prevent stockouts, was not being used as planned. **An in-depth investigation of the drug value chain is needed to understand breakdowns in the system. Moreover, additional training to improve drug requisitions may be useful.** An in-depth investigation of the drug value chain would help understand breakdowns in the system, including why the delivery of medications is often irregular and late, and why drugs requests are frequently not filled appropriately. **It may be helpful to adjust drug delivery approaches according to HZ accessibility and other contextual factors.**
11. Vaccine availability improved, but most vaccines were available at around 70 percent of facilities, and BCG stock rates lagged behind other vaccines**. The vaccine supply chain system should be analyzed for each type of vaccine so that targeted improvements can be made to ensure continuous availability.**
12. There has been an increase in job satisfaction among health workers from baseline to endline.

However, satisfaction at endline was still reported at less than 50 percent. The qualitative data indicated that underlying factors that influenced low satisfaction were primarily linked to poor remuneration. Other factors included difficult working environments and limited opportunities for professional development and advancement. **According to health workers, mitigating the irregular and late delivery of assistance by IPs that can interfere with facility revenue and operations and health worker performance would positively impact on job satisfaction.**

13. CODESAs' implementation of community scorecards has seen mixed results. Although a majority reported receiving training, the number of recent training sessions and implementations had decreased significantly. The qualitative research indicated that those groups that received training were not functioning as planned. **Revitalizing community scorecard training and ensuring consistent support for CODESA members may have an impact on sustained community engagement**.
14. Maternal death rates trended down over the course of the project. Active management of the third stage of labor, HIV testing, and syphilis testing improved, although they remained concerningly low. Rates of blood pressure measurement at ANC1 increased in 2021, it trended back down in 2024**. Continued focus on technical skills in maternal and neonatal health in both HCs and hospitals is warranted.**
15. The percentage of health workers who said that they would prescribe a 22-year-old unaccompanied married woman with no children a contraceptive method increased at both HCs and hospitals in 2024. Although this is promising**, more behavior change communication is needed**, especially around the belief that a woman must prove that she is fertile (by having a child) before she can begin taking contraception. **The qualitative data underline the need to target male partners through behavior change interventions.**
16. USAID IHP contained some aspects of integration, with all focal areas falling under the three project objectives rather than in siloed programs. **Integration could be further emphasized through, for example, integrated care protocols, integrated supportive supervision, integrated health messaging, and gender integration in all service provision.**

Objective 3: Increase the Adoption of Healthy Behaviors, including the Use of Health Services in Target Health Zones

17. The functionality of community health systems has declined due to difficulties in retaining volunteer health workers. Constant turnover impacts the quality of work. **Additional training and support for CHWs are needed.**
18. USAID IHP contributed to the revitalization of CAC and CODESA committees, but many committees were at the end of their three-year mandates by the endline, and it was unclear how subsequent elections would be supported. **Institutionalizing the funding of these committees would help ensure their sustainability.**
19. VIVA interventions received minimal attention from government workers, and there was little mention of radio messages associated with VIVA by community members. **If USAID chooses to continue the VIVA approach, it should increase its efforts to obtain government buy-in.**

20. Mini-campaigns were effective in boosting healthcare use temporarily, but better preparation and organization are needed to ensure the availability of medications and commodities.
21. USAID IHP's approach of establishing contracts with local NGOs was a positive initiative, but deficiencies were identified in the work of some contracted NGOs, requiring **increased monitoring and oversight.**

Future directions

- Many health facilities remain without electricity, cellular connectivity, or Internet, which will continue to significantly limit the success of health programs. Although USAID IHP invested in telecommunications upgrades at HZ offices, health facilities were less of a focus. **Improving the connectivity of health facilities** would enable both routine and MAPEPI case reporting, facilitate remote supervision, give health workers access to information, and allow for online banking.
- Many health facilities are in dire need of rehabilitation. Poor conditions of health facilities impact health worker satisfaction, service quality and patient safety, and service use. However, it is not sustainable for USAID to fund one-time rehabilitation of facilities. Rather, a future program could work with the MOH to **establish a resourced process by which health facilities receive planned regular maintenance and as-needed repairs.**
- Health financing schemes were not a focus of USAID IHP. Although mining royalties were invested in equipment, little was done to promote financial protection for individuals. This places financial stress on health facilities, as evidenced by the rise in punitive practices against patients who cannot pay. It likely also impacts health worker satisfaction and certainly impacts their salaries. **Globally, there are many models of health financing that could be tested in a future program**, such as PBF, government-subsidized free care, social health insurance, community-based health insurance, vouchers, cash transfers, and health equity funds.
- USAID IHP did not invest in referral systems, which function poorly. It would be beneficial to **carry out research to better understand the importance of barriers to acceptance of timely referrals and inform ways to improve the referral system**. In addition, USAID may consider using the data from the facility survey to carry out a **mapping exercise to delineate referral facilities, distances between facilities, and the services offered**. **Establishing systems to ensure rapid transport** at the community level should also be explored.
- Although USAID IHP conducted much training, it faced challenges in reaching all health workers with quality instruction, and in maintaining a trained workforce due to frequent turnover. This is a perpetual issue in time-limited, donor-funded projects such as USAID IHP. There are different tactics that may be more efficient and effective.
    - First, USAID IHP could **invest in improving pre-service training**. Producing highly skilled health workers at educational institutions that are mainly located in urban areas may be more efficient than trying to reach them once they have moved to their posts.
    - USAID could build on the improvements in the connectivity of health facilities **to establish online options for continuing education**. This could be done in partnership with schools of public health in the DRC. The clinical vignette model used in the evaluation, which was well-received, may be one way to structure a training. USAID could explore whether tying opportunities for professional advancement to completion of continuing education would improve health worker motivation and skill levels.
    - Although not an entirely new direction, integrated, **supportive supervision and clinical**

mentoring could be another tactic for ensuring that health workers provide quality services.

- Almost universally, indicators of service readiness either improved or stayed the same over the course of USAID IHP. The majority of improvements occurred at HCs. Furthermore, in absolute terms and despite being a higher level of care, hospitals do not necessarily outperform HCs in indicators of service readiness. This aligns with findings about facility supervision that showed that hospitals were less likely to be supervised. **In future programs, USAID should consider a separate strategy tailored to the unique needs of hospitals.**
- In addition to USAID IHP's work on promoting gender equity in health, **USAID could support an assessment of gender equity among health workers.** This could include differences in pay, the division of labor, professional opportunities, and safety in their communities and at work. This assessment could inform an approach to improve gender equity in the health system, as needed.
- Last, the resources dedicated to nutrition and WASH during USAID IHP were not commensurate with the need. This was reflected in the impact evaluation, where increases in acute malnutrition and severe diarrhea cases were observed in USAID IHP-supported areas. Whether these focal areas are better placed in an integrated health program or as stand-alone programs may be context dependent. However, the status of the population's health will continue to be limited if their access to food and water remains tenuous. **Because these issues are likely to be compounded in the future due to the effects of climate change, serious attention and future investment in nutrition and WASH should be seriously considered.**

Conclusion

This evaluation assessed the outcomes and impacts of USAID IHP in the DRC between 2019 and 2024. Program implementers dealt with significant challenges, including the COVID-19 pandemic, a nurses' strike, and budget cuts. Despite these challenges, positive changes in health system functioning and health outcomes were achieved. A future program could build on the model of USAID IHP while learning from and improving the areas in which it did not meet its goals. Furthermore, USAID could consider expanding the focus of the program to include additional aspects of health system strengthening, thus improving its prospects for sustainability.

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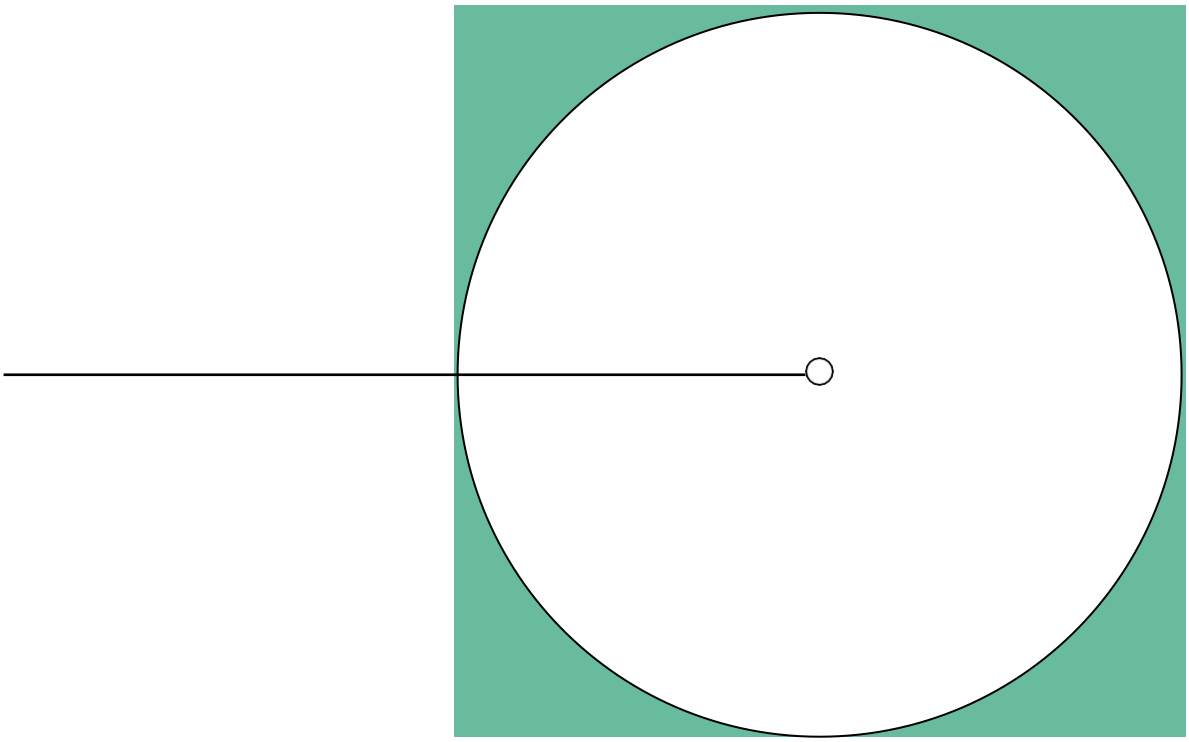
Appendix 1. Evaluation Statement of Work



Data for Impact
Work Plan

IHP-DRC Evaluation: Year 6
October 1, 2023 - September 30, 2024

Approved: September 15, 2023

USAID FROM THE AMERICAN PEOPLE

DATA FOR impact

D4I-DRC-001: IHP-DRC Evaluation

Activity Lead: Hotchkiss, David R

USAID Primary Backstop: Rawlins, Barbara

Y6 Budget: $1,498,202

Needs Statement

USAID/DRC requested Data for Impact (D4I) to carry out an independent impact evaluation to determine the effectiveness of interventions supported by the USAID Integrated Health Program (USAID IHP) on several types of outcomes, including: the health system's leadership and governance, access to quality, integrated health services, and the practice of key healthy behaviors. This activity is addressing that need by conducting a mixed methods performance and impact evaluation.

Additionally, D4I is implementing evaluation capacity strengthening interventions at the Kinshasa School of Public Health. The outcomes of these activities will be assessed via an internal evaluation during the final year of the program.

Workplan

Introduction

In response to a request from USAID/DRC, D4I is conducting an independent evaluation to assess the effectiveness of the USAID Integrated Health Project (USAID IHP) on several types of outcomes, including: health system leadership and governance, access to quality, integrated health services, and the practice of key healthy behaviors. The evaluation consists of several study components that are being implemented over a seven-year period, including the estimation of an impact evaluation model that combines difference-in-differences with propensity score matching using DHIS2 data, a facility-level and health zone (HZ) office-level assessment of changes over time in USAID IHP-supported areas, a qualitative analysis, and a lives saved analysis. In addition, D4I plans to strengthen evaluation research capacity of the Kinshasa School of Public Health (KSPH).

Background

The overall purpose of the evaluation is to assess the effectiveness of IHP's health system strengthening strategies. The specific research questions that will be addressed in the evaluation are the following:

(1) Did the expected changes in outcomes and impacts occur?

- Strengthen health systems, governance, and leadership at provincial, HZ, and facility levels in target HZs.

- Outcome: Enhanced capacity (institutional and individual) of provincial health offices, HZs, and facilities to plan, implement, monitor, oversee and supervise services
- Outcome: Strengthened capacity of CSO's and community structures to provide health systems oversight

- Increase access to quality, integrated health services in target HZs.
  - Outcome: Increased availability of quality, integrated facility-based health services and commodities
  - Outcome: Increased availability of quality, integrated community-based health services
  - Outcome: Improved affordability of integrated health services

- Increase adoption of healthy behaviors, including health service use, in target HZs
  - Impact: Proportion of children under 5 for whom treatment/advice was sought for ARI, diarrhea, and fever*Impact: Proportion of children under 5 who slept under an Insecticide-
    Treated Net
  - Impact: Proportion of married women using any modern method of contraception
  - Impact: Proportion of children who received all eight basic vaccinations
  - Impact: Proportion of pregnant women who attend four ANC visits
  - Impact: Proportion of newborns cared for using the Kangaroo method
  - Impact: Proportion of newborns placed on the breast within one hour of birth
  - Impact: Proportion of children under 6 months breastfed exclusively

(2) If there were changes in healthy behaviors over the course of the study period, to what extent were these attributable to USAID IHP?

(3) Did the project contribute to gender equity in health services and within the health system?

(4) What factors enabled or limited the success of USAID IHP?

- Design/scope
- Implementation/management
- External environment/contextual factors
- Government decentralization

As described in the evaluation research protocol, the D4I team is using mixed methods to analyze and triangulate data from the health management information system (DHIS 2), primary survey data, and qualitative data. The specific methods and data sources are as follows:

- Analysis of impact using a difference-in-differences with propensity score matching approach. A doubly robust model that combines difference-in-differences with propensity score matching (DID-PSM) will be used to estimate the impact1 of USAID IHP on the provision of maternal and child health care services and family planning services (as identified in Research Question 2). The unit of analysis will be the HZ. The treatment arm includes HZs in USAID IHP provinces (based on data

from both hospitals and health centers/posts) in the pre-intervention (2017-18) and post-intervention (2019-23) periods and the control arm includes comparable HZs without USAID IHP support. The DID-PSM estimates of project impact will include HZ-level fixed effects to adjust for time-invariant factors including baseline differences between USAID IHP-supported HZs and control HZs as well as location and socio-economic characteristics. To the extent allowed by our data, which come from the health management information system, the DID-PSM model will also include time-variant controls for volume of cases across health care facilities, and socio-economic characteristics, and account for the staggered implementation of USAID IHP. To account for serial correlation in monthly HZ outcomes, standard errors will be clustered by HZ. By including HZ and month fixed effects, the DID-PSM model uses trends in outcomes in the control HZs as the counter-factual for what would have happened in the treatment group without USAID IHP. D4I will subcontract our former post- doc, Matt Worges, to assist with the final analysis.

- Analysis of facility-, HZ office-, and provincial health office-level changes over time. To evaluate the progress of IHP-supported areas on service readiness, service quality, and service utilization, a separate analysis component will use data from provincial health offices, HZ offices, health facilities and health centers and hospitals, which we will collect, and data from baseline and endline facility and household surveys that USAID IHP is collecting independently (note that this is dependent on Abt conducting an endline household survey). This is the performance evaluation component of the overall study. As USAID IHP is operating in all HZs within its nine provinces, it is not feasible to identify and survey a comparable control group of HZs within these same provinces. Comparisons will be made in selected indicators between baseline (Year 1), midline (Year 4), and endline (Year 7). To conduct the comparisons, the absolute changes for each indicator value will be compared between survey waves using t-tests or Chi2 tests, both overall and for the three regional sub-groups. We will also stratify results by sex and age when applicable.

- Qualitative analysis. To assess the perceptions of various stakeholders on the implementation of USAID IHP-DRC supported interventions, qualitative data is being collected at baseline, midline, and endline. At baseline, data was collected in Kinshasa and in one province. In addition to Kinshasa data collection, at mid-point and endline qualitative data will be gathered in one province located in each of the three regions of the intervention. Methods will include key informant and in-depth interviews, observations, and focus group discussions with community members/patients, community health committee members, health workers, HZ staff, provincial staff, staff in Kinshasa, and implementing partner representatives. All qualitative data will come from areas receiving project support.

- Lives saved analysis. If Abt Associates repeats their 2019 population-based household survey at endline, the Lives Saved Tool (LiST) will be used to evaluate the health impacts of USAID IHP at endline. Actual changes in coverage between baseline and endline will be compared to the changes targeted.

Description of Years 1-5 activities

During Year 1 (October 1, 2018 to September 30, 2019), a research protocol was developed (funded via the MEASURE Evaluation Phase IV mechanism) and baseline data collection and analysis activities were initiated. In addition, an assessment of the capacity of KSPH to conduct evaluation research was carried out.

During Year 2 (October 1, 2019 to September 30, 2020), data from the baseline survey, DHIS2 service data, and data from the first wave of qualitative work were analyzed and an interim baseline report was produced. David Hotchkiss presented the evaluation methodology at the American Evaluation Association conference in April 2020. Findings from this research were presented three times: (1) to USAID mission staff, Abt

Associates, and other partners in Kinshasa in January 2020, (2) at the D4I USAID partners (virtually) meeting in June 2020, and (3) to representatives of the DRC Ministry of Health (virtually) in September 2020.

Additional qualitative data were collected; these qualitative findings, along with data from Abt's baseline household survey, were added to the final version of the baseline report. Results from the baseline evaluation capacity assessment were used to develop a capacity strengthening plan for KSPH.

During Year 3 (October 1, 2020 to September 30, 2021), the midline facility survey and qualitative data collection was conducted and data analysis for the midline evaluation report was carried out. Activities described in the capacity strengthening plan were implemented at KSPH. D4I also began to collaborate with USAID IHP on three studies that contribute to the project's Learning Agenda. Additionally, D4I organized a satellite session on the use of routine health information system data in health systems evaluation at the Sixth Global Symposium for Health Systems Research that was held virtually in November 2020.

During Year 4 (October 1, 2021 to September 20, 2022), D4I conducted the following activities:

- Midline evaluation data analysis, report writing, and dissemination. The D4I team traveled to Kinshasa for a two-day dissemination meeting in January 2022. The meeting was attended by implementing partner staff and representatives from the Mission. An addendum to the midline report, which included additional qualitative data, was also released in January 2022. A virtual dissemination meeting for the province-based implementation staff and the Ministry of Public Health was held in September 2022. Four French language research briefs were released in September 2022.

- Annual impact evaluation report. The second installation of the annual impact evaluation report, which uses data from the DHIS2, was submitted to USAID in March 2022.

- Learning Agenda. D4I continued to collaborate with USAID IHP on three learning agenda studies for the project, which are described below.

- A retrospective evaluation of the VIVA campaign. The goal of this study is to inform future implementation of VIVA. Data collection for this study began in November 2022.

- An assessment of health facility supervision. During Year 4, qualitative data was collected, and diary entries from facility-based workers were solicited. Data analysis is ongoing.

- An assessment of the management information system (MIS) for medical equipment. Qualitative data were collected from three provinces, and data analysis is ongoing.

- It should be noted that the research and technical assistance related to supply chain strengthening that USAID had requested is no longer needed, per a discussion between Dr. Wisniewski and USAID Mission staff in Kinshasa in September 2022. Therefore, the associated benchmarks and deliverables from the previous workplan will not be completed.

- Implementation of the evaluation capacity strengthening plan for KSPH. In partnership with Tropical Health, D4I supported the development of an eLearning platform and a community of practice for evaluation at KSPH. Pilot testing of the platform began in September 2022.

During Year 5 (October 1, 2022-September 30, 2023), D4I conducted the following activities:

- Impact evaluation. D4I produced an annual impact evaluation based on DHIS2 data, completed the qualitative addendum report from midline, and created an infographic based on the midline data.

- Studies for the USAID IHP Learning Agenda. D4I completed the three learning agenda studies.

- Supervision study: D4I completed data analysis and wrote the study report.
- Medical equipment information system study: D4I completed data analysis and wrote the study report.
- VIVA! study: D4I collected data, transcribed data, coded data, completed data analysis and wrote the study report.

- Capacity strengthening with KSPH. The online community of practice, launched in Year 5, is a platform through which KSPH affiliates can discuss evaluation topics and collaborate on proposals and research. The eLearning platform contains six modules that D4I and Tropical Health created (listed below). Additionally, KSPH plans to add their own modules.
  - Évaluation: rôle et fonction dans la gestion globale du cycle de projet (Evaluation : role and function in overall project cycle management)
  - Système d'évaluation de projet (Project evaluation system)
  - Différents types d'évaluation de projet (Different types of project evaluation)
  - Planification et élaboration du protocole et mise en œuvre d'une évaluation (Protocol development and evaluation implementation)
  - Collecte de données (Data collection)
  - Analyse, reportage et dissémination (Analysis, reporting and dissemination)
- Conference presentations. D4I presented research from their portfolio in the DRC at the following conferences:
  - International Conference on Family Planning in November 2022: Measuring Family Planning Quality of Care through Clinical Vignettes: Experience from Nigeria and the Democratic Republic of Congo (oral presentation)
  - American Evaluation Association in November 2022: Data quality assessment and use of routinely reported health facility data to evaluate a policy initiative in the Democratic Republic of the Congo (oral presentation)
  - Seventh Global Symposium for Health Services Research in November 2022: Community health worker expectations and how community health programs can increase volunteer motivation in the Democratic Republic of the Congo (poster presented virtually); and Acceptability of COVID-19 Prevention and Control Measures in the Democratic Republic of the Congo (poster presented virtually)
  - International Maternal Newborn Conference in May 2023: Using clinical vignettes to assess maternal and newborn health provider knowledge and practice: experience from DRC and Nigeria (oral presentation)

Description of Year 6 Activities

The proposed workplan covers the following activities:

- Performance evaluation – quantitative component: In partnership with KSPH, D4I will conduct data collector training in January, and conduct the endline facility survey in nine provinces in January and February 2024. Data from the baseline, midline, and endline surveys will be analyzed and included in the final performance evaluation report, which will be produced by the end of Year 6. The report will

be written in English, with the executive summary translated into French. During fieldwork, our teams will distribute flash drives containing reports, presentations, and research briefs from the midline to health zone offices, as a way to disseminate study findings to them.

- Performance evaluation – qualitative component: In partnership with KSPH, D4I will carry out focus group discussions and in-depth interviews in three provinces, as well as central-level key informant interviews. The qualitative data will be transcribed, coded, and analyzed, then incorporated into the final performance evaluation report.

- Impact evaluation: Using DHIS2 data, D4I will produce the final version of the impact evaluation report, covering the impact of the project since baseline. The report will be written in English, with the executive summary translated into French. We will sub-contract Matt Worges, who conducted the previous rounds of the impact evaluation analysis, to assist with this analysis.

- Dissemination of performance and impact evaluation results: D4I will present the findings of the evaluation to the Ministry of Public Health, USAID, IHP implementing partners, and other stakeholders in Kinshasa in September. Slides will be available in French and English. Additionally, D4I will produce an infographic in French and English summarizing the evaluation's results.

- Capacity strengthening for KSPH: In partnership with KSPH, D4I will conduct an internal evaluation of the capacity strengthening activities. This will involve an endline survey measuring faculty and students' research self-efficacy and exposure to D4I's capacity strengthening activities, as well as interviews with School leadership covering their views on the implementation, impact, and sustainability of the initiative. Findings will be presented in a capacity strengthening evaluation report that will be produced in both English and French.

Gender Considerations

Data collection: Efforts have been made to achieve gender equality in the composition of data collection teams. At least three of the nine field supervisors will be women; this is the same proportion as in the baseline where two of the six supervisors were women. Field supervisors in charge of recruiting data collection teams are held accountable for recruiting women and have been trained on strategies to target them. However, as women in DRC tend to have lower education levels compared with men, and the work requires data collectors to be away from home (and small children) for extended periods, it may not be possible to achieve full equality.

We will assess whether USAID IHP contributed to gender equity in health services and within the health system. We will also disaggregate data by sex as appropriate.

In the capacity strengthening evaluation, we will disaggregate by gender if the number of female respondents is large enough to ensure confidentiality. Women are not well-represented within KSPH's faculty or graduate student body.

Assumptions

Due to the challenging context of the DRC, D4I has diversified the sources of data on which this evaluation relies. However, the ability to conduct the evaluation in its entirety assumes the continued availability of DHIS2 data, and safe access to project areas during data collection periods. The DRC is scheduled to hold a presidential election in December 2023. Any related disruptions or unrest could complicate data collection. Additionally, natural disasters (such as the flooding in Sud Kivu in May 2023) or disease outbreaks could make data collection more challenging. These challenges would continue to be mitigated as much as possible,

for example, by conducting interviews virtually or emailing survey or interview questions for electronic response. Data collectors will follow local regulations regarding travel and health precautions and will be provided with training and materials (masks and sanitizer) to mitigate risk. The completion date for the final report is dependent upon a timely response by the reviewers.

Benchmarks

Benchmark	Estimated Completion Date*
Performance evaluation: Qualitative contract with KSPH signed.	November 2023
Performance evaluation: Survey contract with KSPH signed.	November 2023
Performance evaluation: Qualitative data collector training.	January 2024
Performance evaluation: Survey data collector training.	January 2024
Capacity strengthening: evaluation data collection.	January 2024
Performance evaluation: Qualitative data collection.	February 2024
Capacity strengthening: evaluation data analysis.	February 2024
Performance evaluation: Survey data collection.	February 2024
Performance evaluation: Qualitative data transcription.	March 2024
Performance evaluation: Survey data cleaning.	March 2024
Impact evaluation: Subcontract for analysis signed.	April 2024
Capacity strengthening: evaluation report drafted.	April 2024
Performance evaluation: Qualitative data analysis.	May 2024
Performance evaluation: Survey data analysis.	May 2024
Performance evaluation: Report drafted.	June 2024
Performance and impact evaluation: Dissemination presentation drafted.	June 2024
Impact evaluation: DHIS2 data acquired	July 2024
Impact evaluation: Analysis conducted.	July 2024
Impact evaluation: report drafted.	August 2024
Performance and impact evaluation: Infographic drafted.	August 2024
Performance and impact evaluation: Dissemination event invitations sent.	August 2024

*These dates assume a work plan start date of October 1, 2023. If delays in work plan approval or the receipt of funding delay the start date, these dates will be automatically adjusted to account for the delay.

Deliverables

Deliverable	Estimated Completion Date*
Endline survey data set	September 2024
Capacity strengthening evaluation report (English and French)	April 2024
Performance evaluation report	July 2024
Impact evaluation report	August 2024
Infographic (English and French)	August 2024
Dissemination presentation: Impact evaluation (English and French)	September 2024
Dissemination presentation: Performance evaluation (English and French)	September 2024

*These dates assume a work plan start date of October 1, 2023. If delays in work plan approval or the receipt of funding delay the start date, these dates will be automatically adjusted to account for the delay.

The deliverables related to the performance and impact evaluation will be used to inform future health investments in the DRC. The capacity strengthening evaluation report will be used to better equip the public health workforce in the DRC to create and use evidence in health programming.

Annual Performance Targets

The objective of the D4I award is to increase capacity for rigorous evaluation. To that end, the project has three IRs. The work performed under this work plan is expected to contribute to project indicators under three of the project IRs as follows:

- IR1: Evidence generated
    - Assessments/evaluations completed
    - Data sources made publicly available
- IR2: Capacity strengthened
    - Local organizations engaged for collaborative implementation of an assessment or evaluation
- IR3: Data communication and use
    - Data visualization and/or communication products/resources developed and shared with stakeholders
    - Instances of data used for program or policy decision(s)

Budget

Line Item	Assumptions	Total
Personnel	• 76 days of LOE for activity lead • 94 days of LOE for co-activity lead • 117 days for qualitative researcher • Knowledge Management staff support	$342,264
Travel	• 5 trips from New Orleans, LA, to DRC for training, data collection and dissemination – 14 days each trip • 1 trip Baltimore, MD, to DRC for qualitative data collection – 37 days total • In-country travel for qualitative data collection – 32 days total • 1 trip Baltimore, MD, to DRC for dissemination – 14 days	$138,929
Contracts	• Independent individual contracting agreement to KSPH for quantitative and qualitative • Consultant for qualitative data collection – 8 days • Consultant for impact evaluation analysis – 5 days	$1,004,669
Other Direct Costs	• Data collection field costs, printing • USB drives • Dissemination event	$12,340
	Total	$1,498,202

Below is more detail on the budget.

- Personnel
    - The activity lead (David Hotchkiss) will oversee all core D4I activities as related to the workplan. This involves liaising with key counterparts, partners and USAID to implement workplan activities, and ensure there are adequate resources for implementation and dissemination.
    - The co-activity lead (Janna Wisniewski) will oversee the implementation of data collection, and analysis, and the production of reports and other dissemination materials.
    - The qualitative researcher (Lauren Blum) will lead the qualitative research team. Under the direction of the co-activity leads, she will develop data collection tools, train staff, oversee fieldwork, and lead data analysis and writing for the qualitative component. She will also participate in dissemination activities.
    - Knowledge management staff will provide technical review, editing, and formatting of all deliverables.

- A doctoral student at Tulane University, Jonathan Niles, will assist with evaluation activities. However, as his research time is supported by a scholarship, his salary is not charged to this evaluation.

- Travel
  - Travel is detailed below in the "expected international travel" section. Lauren Blum is based in Baltimore, MD, and David Hotchkiss, Janna Wisniewski, and Jonathan Niles are based in New Orleans, LA.

- Contracts
  - The Kinshasa School of Public Health will be sub-contracted to collect quantitative (i.e., facility survey) data, and qualitative (i.e., interview and focus group) data. KSPH faculty and students will also assist with analysis and dissemination. The amount of this subcontract will be $778,579.
  - A DRC-based qualitative researcher will be sub-contracted to assist with data collection and analysis for the internal evaluation of evaluation capacity strengthening activities at KSPH.
  - Matt Worges, who was previously a post-doctoral fellow and who conducted the original impact evaluation analysis, will be sub-contracted to provide technical assistance and quality assurance for the impact evaluation report.

- Other direct costs
  - Data collection field costs and printing are in support of the qualitative data collection. Field costs for quantitative data collection, a much larger undertaking, are included in KSPH's budget for the facility survey.
  - USB drives will be loaded with baseline and midline deliverables (i.e., reports, presentations, infographics) and given to health zone offices during endline data collection, as a mechanism for disseminating findings back to stakeholders who provided the data.
  - A one-day dissemination event in Kinshasa for 100 people is planned.

D4I is a centrally funded cooperative agreement mechanism. The advantage of the assistance mechanism is to allow flexibility to be able to respond to critical, emerging mission needs throughout the year. The workplan associated with this budget gives a list of deliverables and benchmarks broken down by activity. The activity budgets represented in this table are the work plan budgets are specific to **D4I-DRC-001: DRC IHP Evaluation Year 6**. The budget total is being approved by the mission at an activity level understanding the line items within each activity could vary based on the needs in implementing the work plan to achieve the deliverables and benchmarks. **Allocable Cost Factor (ACF)*** is allocated proportionally across line items.

***ACF** is another term for Project Management or Project Administration. ACF is a methodology developed by USAID's Global Health Bureau Field Support system to ensure that the operation costs of all USAID Central Projects are proportionally distributed across all sources of funding. ACFs are required for all USAID Central Projects that get mission field support. In the past, Core or Global funds typically "subsidized" all country programs by paying for virtually all U.S. headquarters costs. USAID requires that Field Support be fully loaded so that Global and Field Support funding share equally in the cost of running the program. The Field Support system now requires that "all estimates and expenditure must be fully loaded, and must include all overhead, indirect, and other attributable and allocable costs on a prorated basis – even when these costs are incurred at the home office of another location. Global core funds are not intended to be used – and are insufficient – for these costs." Headquarters' operational costs (allocable costs) on all USAID central projects should be distributed across cost centers using the ACF.

As alluded to above, allocable costs are pre-defined program management functions of the project that

benefit all project activities that cannot be directly attributable to a specific activity or for which the cost of attributing the cost is too administratively burdensome to be cost effective. Allocable rates do not make a project more or less expensive. Like indirect rates, it is an effective and efficient way of equitably distributing costs that are too difficult to directly charge. The use of a rate is beneficial because it requires less complex coding and time recording, it is easier to budget and track, and provides an indicator to assess financial investment and performance.

Examples of items that are billed to ACF include project headquarters operations costs, concept negotiation, initial work plan discussions, financial and results reporting, project management for the award as a whole, knowledge management, website and systems maintenance, financial management, IT, and administration of the project, and any other expense that is attributable to the project as a whole. Most common in centrally managed, global projects like this one, where the project must report across numerous Operating Units and funding streams, project management expenses cannot bill to just one country or activity. This is charged as funds are expended.

Expected International Travel

From	To	Quarter	Primary Purpose	# Travelers
Baltimore	Kinshasa, DRC	Y6Q2	Qualitative training and data collection	1
New Orleans	Kinshasa, DRC	Y6Q2	Train survey data collectors and collect data for KSPH capacity strengthening evaluation	2
Baltimore	Kinshasa, DRC	Y6Q4	Endline dissemination activities	1
New Orleans	Kinshasa, DRC	Y6Q4	Endline dissemination activities	3

Appendix 2. Other Projects That Were Active in USAID IHP-Supported Provinces

Projects Funded by USAID (1/4)			
Project	**Implementing Partner**	**Provinces**	**Years Active**
Cross-Cutting Issues			
Breakthrough Action (BA)	John Hopkins University (JHU)	All USAID IHP target provinces	2017–2022, extended to 2022– 2025
Global Health Supply Chain – Technical Assistance/Francophone Task Order (GHSC-TA)	Chemonics International		2017–2023
GHSC-Procurement and Supply Management	Chemonics International	All USAID IHP target provinces	2015–2023
Digital Square	PATH	National activity	2016–2026
Local Health Systems Sustainability (LHSS)	Abt Associates	National activity	2020–2025
GHSC—Rapid Test Kits (RTK)	Chemonics	Haut Lomami	2015–2023
Maternal and Child Health			
MOMENTUM Routine Immunization and Transformation (MRITE)	John Snow International (JSI)	Haut Katanga, Kasai Oriental	2020–2025
UNICEF Polio and Routine Immunization	UNICEF Polio and Routine Immunization	National Activity	2022–2031
IFRC & the DRC's Expanded Program on Immunization	International Federation of the Red Cross (IFRC)		2017–2022
WHO AFR/SD Support for the Eradication of Polio	WHO	National activity	2011–2023
WHO Polio and Immunization II	WHO	National activity	2022–2031

Projects Funded by USAID (2/4)			
Project	**Implementing Partner**	**Provinces**	**Years Active**
Malaria			
IMPACT Malaria	Population Services International (PSI)	Haut Katanga, Haut Lomami, Kasai Central, Kasai Oriental, Lualaba, Sankuru, Sud Kivu, Tanganyika	2018–2023
PMI Measure Malaria	University of North Carolina	Haut Katanga, Haut Lomami, Kasai Central, Kasai Oriental	2019–2024
VectorLink	Abt. Associates	Haut Katanga, Haut Lomami, Kasai Central, Sankuru, Sud Kivu, Tanganyika	2017– 2023
End Malaria Project	Chemonics International	Haut Katanga, Haut Lomami, Kasai Oriental, Tanganyika	2021–2026
Promoting the Quality of Medicines Plus (PQM+)	U.S. Pharmacopeial Convention	All USAID IHP target provinces	2019–2024
Linkages Across the Continuum of HIV Services for Key Populations Affected by HIV (LINKAGES)	FHI 360	Haut Katanga, Lualaba	2014–2021
HIV/AIDS			
Integrated HIV/AIDS Project Haut Katanga	PATH	Haut Katanga	2017–2023
HIV Epidemic Control (HEC) Project -- Lualaba	Kheth'Impilo DRC	Lualaba	2019–2023
Meeting Target and Maintaining Epidemic Control (EpiC)	FHI 360	Haut Katanga, Kasai Oriental, Lomami, Lualaba	2019–2024
Enhancing Linkages and Services for Children Affected by HIV AIDS (ELIKA)	Education Development Center (EDC)	Haut Katanga	2016–2021
GHSC—HIV Commodities	Chemonics	Haut Katanga, Haut Lomami	2015–2023

Projects Funded by USAID (3/4)			
Project	**Implementing Partner**	**Provinces**	**Years Active**
Tuberculosis			
TB Local Organizations Network (LON) USAID SASA IVI TB Elimination Project	SANRU	Kasai- entral, Kasai Oriental, Lomami, Sankuru, Sud Kivu, Tanganyika	2020–2025
TB LON Reduce TB	Humana People to People	Haut Katanga, Haut Lomami, Lualaba	2021–2026
Tuberculosis Implementation Framework Agreement (TIFA)	John Snow, Inc.	National program	2019 –2024
TB Data, Impact Assessment, and Communications Hub (TB DIAH)	University of North Carolina	National program	2018–2023
Sustaining Technical and Analytic Resources Project (STAR)	Public Health Institute	National program	2018– 2023
Infectious Disease Detection and Surveillance (IDDS)	ICF, Inc.	National program	2018– 2023
Water Supply and Sanitation			
USAID's Sustainable Water and Sanitation System Activity	Mercy Corps	Sud Kivu	2020–2025
Accelerating Peri-Urban Water and Sanitation Services in Kasai Oriental and Lomami Provinces Activity (DRC PERI-URBAN WASH)	Chemonics	Haut Katanga, Kasai Oriental, Lomami, Lualaba	2020–2025
DCAR –Projet Renforcement et Efficacite des Services Eau en RDC (RESE II)	GIZ	Kasai Oriental, Lomami, Sud Kivu	2021–2025
Sustainable Water and Sanitation Systems Activity (SWASSA)	Mercy Corps	Sud Kivu	2020–2025

Projects Funded by USAID (4/4)			
Project	**Implementing Partner**	**Provinces**	**Years Active**
Democracy, Human Rights, and Governance			
Integrated Governance Activity (IGA)	Development Alternatives, Inc.	Kasai Central, Kasai Oriental, HautKatanga, Lualaba, Sud Kivu	2017–2022
Media Sector Development Activity	FHI 360	Haut Katanga, Kasai Central, Kasai Oriental, Lualaba, Sud Kivu, Tanganyika	2019–2024
Sexual and Gender-Based Violence			
Counter Gender-Based Violence	IMA World Health	Sud-Kivu	2017–2022
Integrated Youth Development Activity (IYDA)	Education Development Center (EDC)	Sud-Kivu	2018–-2022
MOMENTUM Safe Surgery in Family Planning and Obstetrics (MSSFPO)	Engender Health	Lualaba, Sud Kivu	2020–2022
Humanitarian GBV Programming	CARE, Danish Refugee Council (DRC), Danish Church AID (DCA), Doctors of the World (DotW), International Medical Corps (IMC), International Rescue Committee (IRC), Norwegian Refugee Council (NRC), Save the Children Foundation (SCF)	Eastern Region	2021
Bureau for Humanitarian Assistance			
Budikadidi Development Food Security Activity	Catholic Relief Services (CRS)	Kasai Oriental	2017–2021
Enyanya Development Food Security Activity Sud Kivu and Tanganyika	Mercy Corps	Sud Kivu, Tanganyika	2016–2021

Projects Funded by Other Donors			
The Health Strengthening for Better Maternal and Child Health Results Project (PDSS)	World Bank	National program	2014-2024
UNICEF Polio and Routine Immunization	UNICEF Polio and Routine Immunization	National activity	2022–2031
IFRC & the DRC's Expanded Program on Immunization	International Federation of the Red Cross	National Program	2017–2022
WHO AFR/SD Support for the Eradication of Polio	WHO	National activity	2011–2023
WHO Polio and Immunization II	WHO	National activity	2022–2031
WHO Consolidated Grant II	WHO	National program	2021–2026

Appendix 3. Disclosure of Conflict of Interest for USAID Evaluation Team Members

Name	David Hotchkiss
Title	Professor
Organization	Data for Impact / Tulane University
Evaluation Position	☒ Team Leader ☐ Team Member
Evaluation Award Number (contract or other instrument)	Associate award 7200AA18LA00008
USAID Project(s) Evaluated (Include project name(s), implementer name(s), and award number(s), if applicable)	Integrated Health Program in the Democratic Republic of Congo, implemented by Abt Assoc.
I have real or potential conflicts of interest to disclose.	☐ Yes ☒ No
If yes answered above, I disclose the following facts: Real or potential conflicts of interest may include, but are not limited to: 1. Close family member who is an employee of the USAID operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated. 2. Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation. 3. Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project. 4. Current or previous work experience or seeking employment with the USAID operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated. 5. Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated. 6. Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation.	Click or tap here to enter text.
I certify (1) that I have completed this disclosure form fully and to the best of my ability and (2) that I will update this disclosure form promptly if relevant circumstances change. If I gain access to proprietary information of other companies, then I agree to protect their information from unauthorized use or disclosure for as long as it remains proprietary and refrain from using the information for any purpose other than that for which it was furnished.	
David Hotchkiss	14 November 2025

Name	Janna Wisniewski
Title	Assistant Professor
Organization	Data for Impact / Tulane University
Evaluation Position	☐ Team Leader ☒ Team Member
Evaluation Award Number (contract or other instrument)	Associate award 7200AA18LA00008
USAID Project(s) Evaluated (Include project name(s), implementer name(s), and award number(s), if applicable)	Integrated Health Program in the Democratic Republic of Congo, implemented by Abt Assoc.
I have real or potential conflicts of interest to disclose.	☐ Yes ☒ No
If yes answered above, I disclose the following facts: Real or potential conflicts of interest may include, but are not limited to: 1. Close family member who is an employee of the USAID operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated. 2. Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation. 3. Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project. 4. Current or previous work experience or seeking employment with the USAID operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated. 5. Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated. 6. Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation.	Click or tap here to enter text.
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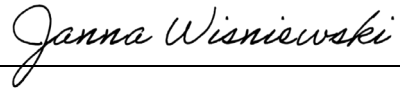
Janna Wisniewski 	November 15, 2024

Name	Jonathan Niles
Title	Doctoral Student / Research Assistant
Organization	Data for Impact / Tulane University
Evaluation Position	☐ Team Leader ☒ Team Member
Evaluation Award Number (contract or other instrument)	Associate award 7200AA18LA00008
USAID Project(s) Evaluated (Include project name(s), implementer name(s), and award number(s), if applicable)	Integrated Health Program in the Democratic Republic of Congo, implemented by Abt Assoc.
I have real or potential conflicts of interest to disclose.	☐ Yes ☒ No
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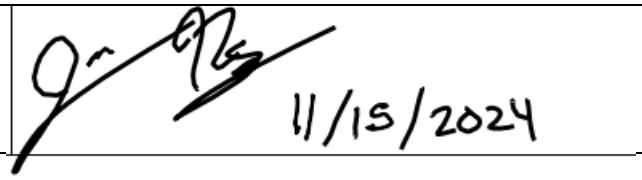
Signature and Date	

Name	Lauren Blum
Title	Adjunct Professor
Organization	Data for Impact/Tulane University
Evaluation Position	☐ Team Leader ☒ Team Member
Evaluation Award Number (contract or other instrument)	Associate award 7200AA18LA00008
USAID Project(s) Evaluated (Include project name(s), implementer name(s), and award number(s), if applicable)	Integrated Health Program in the Democratic Republic of Congo, implemented by Abt Assoc.
I have real or potential conflicts of interest to disclose.	☐ Yes ☒ No
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Signature and Date	Lauren S. Blum November 14, 2024

Name	Paul Samson Lusamba Dikassa
Title	Professor
Organization	University of Kinshasa
Evaluation Position	Team Leader Team Member **X**
Evaluation Award Number (contract or other instrument)	Associate award 7200M18LA00008
USAID Project{s) Evaluated (Include project name(s), implementer name(s), and award number(s), if applicable)	Integrated Health Program in the Democratic Republic of Congo, implemented by Abt Assoc.
I have real or potential conflicts of interest to disclose.	Yes No **X**
If yes answered above, I disclose the following facts: Real or potential conflicts of interest may include, but are not limited to: 1. Close family member who is an employee of the USAID operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s} are being evaluated. 2. Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation. 3. Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project. 4. Current or previous work experience or seeking employment with the USAID operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated. 5. Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated. 6. Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation.	Click or tap here to enter text.
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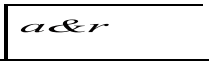
Signature and Date	15 November 2024 

Name	Savannah Badt
Title	Master of Public Health Student/Research Assistant
Organization	Data for Impact/Tulane University
Evaluation Position	☐ Team Leader ☒ Team Member
Evaluation Award Number (contract or other instrument)	Associate award 7200AA18LA00008
USAID Project(s) Evaluated (Include project name(s), implementer name(s), and award number(s), if applicable)	Integrated Health Program in the Democratic Republic of Congo, implemented by Abt Assoc.
I have real or potential conflicts of interest to disclose.	☐ Yes ☒ No
If yes answered above, I disclose the following facts: Real or potential conflicts of interest may include, but are not limited to: 1. Close family member who is an employee of the USAID operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated. 2. Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation. 3. Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project. 4. Current or previous work experience or seeking employment with the USAID operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated. 5. Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated. 6. Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation.	Click or tap here to enter text.
I certify (1) that I have completed this disclosure form fully and to the best of my ability and (2) that I will update this disclosure form promptly if relevant circumstances change. If I gain access to proprietary information of other companies, then I agree to protect their information from unauthorized use or disclosure for as long as it remains proprietary and refrain from using the information for any purpose other than that for which it was furnished.	
Signature and Date	

Name	Steven Dominguez Jr
Title	Doctoral Student
Organization	Data for Impact / Tulane University
Evaluation Position	☐ Team Leader ☒ Team Member
Evaluation Award Number (contract or other instrument)	Associate award 7200AA18LA00008
USAID Project(s) Evaluated (Include project name(s), implementer name(s), and award number(s), if applicable)	Integrated Health Program in the Democratic Republic of Congo, implemented by Abt Assoc.
I have real or potential conflicts of interest to disclose.	☐ Yes ☒ No
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Signature and Date	Steven Dominguez Jr 15 Nov 2024 

Nom	Eric M. Mafuta
Titre	Professeur
Organisation	Université de Kinshasa, Faculté de Médecine, Ecole de Santé Publique
Évaluation Position	☐ Chef d'équipe ☒ Membre de l'équipe
Numéro d'attribution de l'évaluation (contrat ou autre instrument)	Bourse d'associé 7200AA18LA00008
Projet(s) USAID évalué(s) (inclure le(s) nom(s) du projet, le(s) nom(s) de l'exécutant et le(s) numéro(s) d'attribution, le cas échéant)	Programme de santé intégré en République démocratique du Congo, mis en œuvre par Abt Assoc.
J'ai des conflits d'intérêts réels ou potentiels à signaler.	☐ Oui ☒ Non
Si la réponse ci-dessus est positive, je divulgue les faits suivants : Les conflits d'intérêts réels ou potentiels peuvent inclure, mais ne sont pas limités à : 1. Membre de la famille proche qui est un employé de l'unité opérationnelle de l'USAID qui gère le(s) projet(s) évalué(s) ou de l'organisation de mise en œuvre dont le(s) projet(s) est (sont) évalué(s). 2. Intérêt financier direct, ou significatif bien qu'indirect, dans la ou les organisations de mise en œuvre dont les projets sont évalués ou dans les résultats de l'évaluation. 3. Expérience actuelle ou antérieure, directe ou significative bien qu'indirecte, du (des) projet(s) évalué(s), y compris la participation à la conception du projet ou à des itérations antérieures du projet. 4. Expérience professionnelle actuelle ou antérieure ou recherche d'emploi auprès de l'unité opérationnelle de l'USAID chargée de l'évaluation ou de l'organisation (des organisations) de mise en œuvre dont le(s) projet(s) est (sont) évalué(s). 5. Expérience professionnelle actuelle ou antérieure au sein d'une organisation susceptible d'être considérée comme un concurrent industriel de l'organisme de mise en œuvre dont le(s) projet(s) est (sont) évalué(s). 6. Les idées préconçues sur les individus, les groupes, les organisations ou les objectifs des projets et organisations évalués, qui pourraient fausser l'évaluation.	Cliquez ou tapez ici pour saisir le texte.
Je certifie (1) que j'ai rempli le présent formulaire de divulgation de manière complète et au mieux de mes capacités et (2) que je le mettrai à jour rapidement en cas de changement de circonstances. Si j'ai accès à des informations exclusives d'autres entreprises, j'accepte de protéger ces informations contre toute utilisation ou divulgation non autorisée tant qu'elles restent exclusives et je m'abstiens d'utiliser ces informations à des fins autres que celles pour lesquelles elles ont été fournies.	
Signature et date	 24/11/2024

Nom	**YEMWENI DANGU Anicet**
Titre	Attaché de recherche
Organisation	Université de Kinshasa
Évaluation Position	☐ Chef d'équipe ☒ Membre de l'équipe
Numéro d'attribution de l'évaluation (contrat ou autre instrument)	Bourse d'associé 7200AA18LA00008
Projet(s) USAID évalué(s) (inclure le(s) nom(s) du projet, le(s) nom(s) de l'exécutant et le(s) numéro(s) d'attribution, le cas échéant)	Programme de santé intégré en République démocratique du Congo, mis en œuvre par Abt Assoc.
J'ai des conflits d'intérêts réels ou potentiels à signaler.	☐ Oui ☒ Non
Si la réponse ci-dessus est positive, je divulgue les faits suivants : Les conflits d'intérêts réels ou potentiels peuvent inclure, mais ne sont pas limités à : 1. Membre de la famille proche qui est un employé de l'unité opérationnelle de l'USAID qui gère le(s) projet(s) évalué(s) ou de l'organisation de mise en œuvre dont le(s) projet(s) est (sont) évalué(s). 2. Intérêt financier direct, ou significatif bien qu'indirect, dans la ou les organisations de mise en œuvre dont les projets sont évalués ou dans les résultats de l'évaluation. 3. Expérience actuelle ou antérieure, directe ou significative bien qu'indirecte, du (des) projet(s) évalué(s), y compris la participation à la conception du projet ou à des itérations antérieures du projet. 4. Expérience professionnelle actuelle ou antérieure ou recherche d'emploi auprès de l'unité opérationnelle de l'USAID chargée de l'évaluation ou de l'organisation (des organisations) de mise en œuvre dont le(s) projet(s) est (sont) évalué(s). 5. Expérience professionnelle actuelle ou antérieure au sein d'une organisation susceptible d'être considérée comme un concurrent industriel de l'organisme de mise en œuvre dont le(s) projet(s) est (sont) évalué(s). 6. Les idées préconçues sur les individus, les groupes, les organisations ou les objectifs des projets et organisations évalués, qui pourraient fausser l'évaluation.	Cliquez ou tapez ici pour saisir le texte.
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Signature et date	 le 26/11/2°24

Nom	BOSONKIE MOKANISA MARC
Titre	DOCTORANT
Organisation	ECOLE DE SANTE PUBLIQUE DE DE KINSHASA
Évaluation Position	☐ Chef d'équipe ☒ Membre de l'équipe
Numéro d'attribution de l'évaluation (contrat ou autre instrument)	Bourse d'associé 7200AA18LA00008
Projet(s) USAID évalué(s) (inclure le(s) nom(s) du projet, le(s) nom(s) de l'exécutant et le(s) numéro(s) d'attribution, le cas échéant)	Programme de santé intégré en République démocratique du Congo, mis en œuvre par Abt Assoc.
J'ai des conflits d'intérêts réels ou potentiels à signaler.	☐ Oui ☒ Non
Si la réponse ci-dessus est positive, je divulgue les faits suivants : Les conflits d'intérêts réels ou potentiels peuvent inclure, mais ne sont pas limités à : 1. Membre de la famille proche qui est un employé de l'unité opérationnelle de l'USAID qui gère le(s) projet(s) évalué(s) ou de l'organisation de mise en œuvre dont le(s) projet(s) est (sont) évalué(s). 2. Intérêt financier direct, ou significatif bien qu'indirect, dans la ou les organisations de mise en œuvre dont les projets sont évalués ou dans les résultats de l'évaluation. 3. Expérience actuelle ou antérieure, directe ou significative bien qu'indirecte, du (des) projet(s) évalué(s), y compris la participation à la conception du projet ou à des itérations antérieures du projet. 4. Expérience professionnelle actuelle ou antérieure ou recherche d'emploi auprès de l'unité opérationnelle de l'USAID chargée de l'évaluation ou de l'organisation (des organisations) de mise en œuvre dont le(s) projet(s) est (sont) évalué(s). 5. Expérience professionnelle actuelle ou antérieure au sein d'une organisation susceptible d'être considérée comme un concurrent industriel de l'organisme de mise en œuvre dont le(s) projet(s) est (sont) évalué(s). 6. Les idées préconçues sur les individus, les groupes, les organisations ou les objectifs des projets et organisations évalués, qui pourraient fausser l'évaluation.	RIEN A SIGNALER

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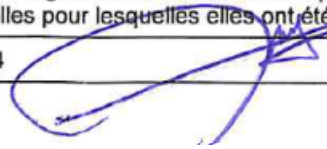
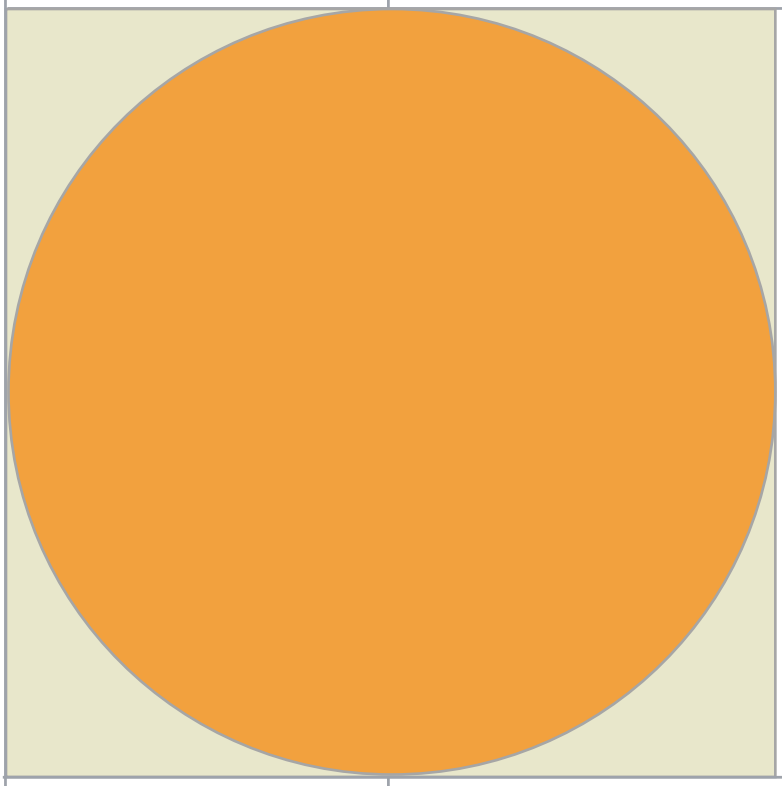
Signature et date	26 Novembre 2024





Data for Impact

University of North Carolina at Chapel Hill
123 West Franklin Street, Suite 330
Chapel Hill, NC 27516 USA

Phone: 919-445-6949

D4I@unc.edu
http://www.data4impactproject.org

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