

Integrating Community Health Program

DEMOCRATIC REPUBLIC OF CONGO COUNTRY SNAPSHOT



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SUPPORT: Nahum Mbuyi (DPS Kinshasa), J Christian Siboko (DSSP/SG), Emilia Ntumba (DSSP/D5), Dorthé Jensen (HPP-Congo), Rachel Ngum (HPP-Congo), Patience Bondengela (HPP-Congo), Michel Lukusa (HPP-Congo), Bodil Sejerde (HPP-Congo), Elyse Zambite (USAID), Dr Michaele Layng (USAID), Lina Piripiri (USAID), Wivine Mbwebwe (USAID), Carla Lopez Castenada (LMH), Lauren Mawe (LMH), Patrick Bukasa (SANRU), Jennyfer Tamba (SANRU), Dr Joseph Ekandji (Jhpiego), Grace Motingia (Jhpiego)

ADDITIONAL THANKS: Brian Bakoko (Action Damien), Constant Bushiri (Action Damien), Michel Mbambula (APSME), Mamie Nyemba (APSME), Florence Meta (ASF/SD), Christelle Mpuekela (ASF/SD), Dr Kalombo Muela (Les Batisseurs), Fabrice Suku-suku (Les Batisseurs), Esperance Nzeba (Caritas Congo), Sandra Senga (Caritas Congo), Jean Luc Gedyegure (CEPAS), Lÿsan Kiteme (Engender Health), Dr Alain Mikato (EngenderHealth), Paulette Mojeke (Engender Health), Augustin Anetubana (Fondation Femme Plus), Rebecca Beusibelte Mulunda (Fondation Femme Plus), Dr. Alex Mayesi (ONG/GRAIN), Alfred Coffi Kousse mou (MEMISA), Joseph Amisi (R-SCS)

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COVER PHOTO CREDIT: USAID Democratic Republic of Congo

PUBLISH DATE: June 2021

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Acronyms

CAC	Community Outreach Unit	<i>Cellule d'Animation Communautaire</i>
CAO	Acceleration Framework for Achieving the MDGs	<i>Cadre d'Accélération pour atteindre les Objectifs du Millénaire pour le Développement</i>
CHSP	Community Health Strategic Plan	<i>Plan Stratégique de la Santé Communautaire</i>
CHW	Community Health Worker	<i>Agent de Santé Communautaire</i>
CNP-SS	National Health Sector Steering Committee	<i>Comité National de Pilotage du Secteur de la Santé</i>
CODESA	Health Area Development Committee	<i>Comité de Développement de l'Aire de Santé</i>
DRC	Democratic Republic of Congo	<i>République démocratique du Congo</i>
ECZS	Health Zone Management Team	<i>Équipe Cadre de la Zone de Santé</i>
GFF	Global Financing Facility for Women, Children and Adolescents	<i>Mécanisme de Financement mondial pour les femmes, les enfants et les adolescents</i>
HPP-Congo	Humana People to People Congo	
iCCM	Integrated Community Case Management	<i>Prise en charge intégrée des maladies d'enfance</i>
ICH	Integrating Community Health Program	
LMH	Last Mile Health	
MDG	Millennium Development Goal	<i>Objectifs du Millénaire pour le Développement</i>
MSP	Ministry of Public Health	<i>Ministère de la Santé Publique</i>
PARTICOM	Strategic Framework for Community Participation in DRC	<i>Cadre Stratégique de la Participation Communautaire en RDC</i>
PCIMNE	Integrated Management of Newborn and Childhood Illnesses	<i>Prise en Charge Intégrée des Maladies du Nouveau-né et de l'Enfant</i>
PNDS	National Health Development Plan	<i>Plan National de Développement Sanitaire</i>
RECO		<i>Relais Communautaire</i>
SDG	Sustainable Development Goal	<i>Objectifs Durable pour le Développement</i>
SRSS	Health System Strengthening Strategy	<i>Stratégie de Renforcement du Système de Santé</i>
SSC	Community Care Site	<i>Site de Soins Communautaire</i>
UHC	Universal Health Coverage	<i>Couverture Sanitaire Universelle</i>
UNICEF	United Nations International Children's Emergency Fund	<i>Fonds des Nations Unies pour l'Enfance</i>
USAID	United States Agency for International Development	<i>Agence des États-Unis pour le développement international</i>
WASH	Water, Sanitation and Hygiene	
WHO	World Health Organization	<i>Organisation Mondiale de la Santé</i>

Preface

Accelerating the Integration of Community Health Worker Programs through Institutional Reform

Approximately half of the world's population do not have access to essential health services. A growing emphasis on the roles of communities recognizes community engagement, including community health workers (CHWs), as a means of realizing the full potential of the primary healthcare (PHC) system.¹ High performing CHW programs at scale are an integral component of responsive, accessible, equitable, and high-quality PHC.

Recognizing the potential for community health to address gaps in coverage, improve financial protection, and support access to quality care, the Declaration of Astana in 2018 committed to strengthening the role of community health in PHC as a means to accelerate progress toward universal health coverage (UHC). Before the Declaration of Astana, the transition from the Millennium Development Goals to the Sustainable Development Goals (SDGs) also helped to reposition communities as resources for health systems strengthening and sources of resilience for individuals and families.

The United States Agency for International Development (USAID) initiated a collaboration with the United Nations Children's Fund (UNICEF) and the Bill & Melinda Gates Foundation in 2016 to advance country commitments toward communities as resources in PHC systems to accelerate progress towards the achievement of the SDGs. The Integrating Community Health (ICH) collaboration fueled a global movement with more than twenty countries to elevate national priorities and progress for institutionalizing community health in primary health care systems. USAID, in collaboration with UNICEF, invested in catalytic partnerships with governments, their trusted NGO partners, and communities across 7 countries (Bangladesh, the Democratic Republic of Congo

(DRC), Haiti, Kenya, Liberia, Mali, and Uganda) to institutionalize reforms and learning, with a focus on CHWs. In alignment with these efforts, the Bill & Melinda Gates Foundation supported the development of new evidence and knowledge regarding performance measurement, advocacy and pathways to scale in the seven focal countries via the Frontline Health Project with Population Council and Last Mile Health as lead partners. Using Last Mile Health's Community Health Reform Cycle framework, the Country Snapshots highlight the ICH collaboration's catalytic partnerships to strengthen national CHW programs as an essential component of PHC and to place these programs within the context of institutional reforms and political commitment needed for national progress in health outcomes.

Re-envisioning health systems to achieve UHC requires leadership and political commitment from within countries. Countries must mobilize the whole society—both public and private sectors as well as communities—as essential resources in this effort. The community component of PHC must be designed to enable the health system to reach the most underserved, respond to pandemics, close the child survival gap, and accelerate the transformation of health systems. Without a major expansion of support for national CHW programs, the measurable acceleration urgently needed to reach the health-related targets of the SDGs by 2030 is unlikely. With a decade remaining to achieve the SDGs and faced with the challenge of the COVID-19 response, building global political momentum with countries and funders is critical to support urgent national priorities, evaluate progress, and develop and share new knowledge to inform bold political choices for a whole of society approach to health systems strengthening.

Community Health Institutionalization as a “Reform Cycle”

The Country Snapshots featured in this series highlight the seven ICH countries’ reform efforts within a framework for institutional reform: the Community Health Systems Reform Cycle (often referred to here as the “reform cycle”).² Countries experience community health systems reform as a process and pathway to institutionalizing community health. The likelihood that any particular reform is successfully institutionalized in an existing policy environment depends on political will and buy-in from key stakeholders, the technical design of the policy, the available capacity and resources to launch and govern the intervention, the ability to learn, and the willingness to adapt and improve the program over time.

The reform cycle framework has guided—and been refined through—a descriptive analysis of the ICH countries’ reform journeys. Country Snapshots, reflecting the ICH investment on community health

systems reform, demonstrate the practical linkages between available literature and specific country experiences. This framework provides health systems leaders with an approach to plan, assess, and strengthen the institutional reforms necessary to prioritize community health worker programs as part of national primary health care strategies to achieve universal health coverage.

The reform cycle traces several stages of institutional reform, which are summarized below. Reforms may encompass an entire community health worker program or target specific systems components, such as health information systems. While reforms may not always follow each stage in sequence and timing can vary depending on the complexity of the program or activity, deliberate and comprehensive planning can strengthen buy-in and overall effectiveness.





PROBLEM PRIORITIZATION

Actors identify a meaningful and relevant problem. They diagnose pain points and unmet needs, and connect them to priority areas for reform, where possible. Actors acknowledge the need for reform within the community health system and commit to a joint vision for addressing gaps.



COALITION BUILDING

A group is formed around a compelling problem or vision. Members define the coalition's goals, roles, size, and composition. Diverse members fill critical roles in the reform effort (e.g., leaders, connectors, gatekeepers, donors, enablers, change champions, and liaisons to key players outside the coalition).



SOLUTION GATHERING

Potential solutions are gathered, drawing from existing local and international programs. Actors define criteria and metrics to assess solutions, and specific ideas for reform are piloted, where possible. Promising solutions are prioritized for integration into the health system.



DESIGN

Key decision makers, stakeholders, and planners map out different options for program design. Where possible, evidence about the options, expected cost, impact, and feasibility are identified. Through consultations, workshops, and other channels, stakeholders offer feedback on options, and decision makers select a design. This may include operational plans, training materials, job descriptions, management tools, data collection systems, and supply chain processes.



READINESS

Coalition members and champions prepare for launch by getting buy-in from actors instrumental to the launch, rollout, and maintenance of the program. Stakeholders also translate program design into costed operational plans that include clear strategies and tools for launch and rollout. Investment plans for sustainable financing and funding mechanisms are put in place. Stakeholders are prepared for their new roles and responsibilities, and potential areas of policy/protocol conflicts are addressed.



LAUNCH

New policies, processes, and organizational structures are implemented, and key actors execute their new roles. As these shifts progress, learning is gathered to demonstrate momentum and identify challenges to achieving scale. Particular attention is paid to issues around rollout, and timely design and implementation shifts are made as needed.



GOVERNANCE

Stakeholders establish a project governance framework, which includes key leadership and decision-making bodies, clear roles and responsibilities, and explicit decision rights. Processes for risk and issue management, stakeholder engagement, and cross-functional communication are established. Actors monitor program progress to advance clear decision-making and address critical issues or challenges.



MANAGEMENT & LEARNING

Key stakeholders regularly review program data to inform problem-solving at the national or subnational level. Stakeholders engage in continuous learning and improvement, identifying challenges and changes to program design and other systems bottlenecks.

Country Snapshots of Institutional Reform

PURPOSE AND GOALS OF COUNTRY SNAPSHOTS

- Describe the community health landscape within each country
- Present the country's vision for community health reform and situate progress to-date within the framework of the reform cycle
- Articulate the primary community health institutionalization challenges that the country is or was facing at the outset of the ICH investment
- Trace the policy and advocacy process taken by country stakeholders to move reform forward, using the ICH investment as a catalyst
- Identify lessons learned and opportunities for strengthening existing reforms arising out of the ICH investment

The Country Snapshots complement other resources generated within and beyond the ICH investment, such as the countries' Community Health Acceleration Roadmaps, ICH Country Case Studies, and Frontline Health Project Research Studies. The Country Snapshots place a unique emphasis on tracing the process of policy choice, advocacy, and implementation. Together, these complementary initiatives are catalyzing community health systems reform and advancing efforts towards a strong primary health care system and UHC.

APPROACH AND METHODS

The Country Snapshots highlight examples of a country's reform journey through the specific stages of institutionalization outlined in the framework. Country Snapshots both demonstrate the features of each stage within the country context and elevate salient examples of countries' learning and success. The Country Snapshots reflect a process of desk reviews and consultations with country stakeholders. Stakeholders include but are not limited to current and former ministry of health representatives, leaders from non-governmental and technical organizations, and members of multilateral and bilateral institutions. The Country Snapshots elevate both existing

insights captured in policy and strategy documents that are often difficult for those not working within the country to access, as well as novel perspectives gained through methods such as workshops or in-depth interviews with key stakeholders. Where the Country Snapshots draw on existing materials, citations are noted. Insights and country stakeholder recommendations on the reform cycle's application serve not only to validate the framework, but also to highlight ways in which the framework can help trace powerful narratives of reform and accelerate community health systems policy and advocacy efforts.

These narratives reveal opportunities to accelerate the prioritization of community health worker programs and primary health care strategies with the goal of UHC. The Country Snapshots reflect valuable feedback from stakeholders on how the framework can help advance community health systems policy and advocacy.

Key Resources

- [USAID Vision for Health Systems Strengthening 2030](#)
- [Astana Declaration](#)
- [CHW Resolution](#)
- [CHW Guidelines](#)
- [Exemplars—Community Health Workers](#)
- [Community Health Roadmap](#)
- [Institutionalizing Community Health Conference 2017](#)
- [Institutionalizing Community Health Conference 2021](#)
- [Community Health Community of Practice](#)
- [Global Health: Science and Practice Supplement 1: March 2021](#)
- [Journal of Global Health: Advancing Community Health Measurement, Policy and Practice](#)

DRC's Community Health Policy and Advocacy Landscape

Health Access and Outcomes

The sheer size, diversity, and socio-political dynamics of the Democratic Republic of Congo (DRC) complicate its governance and provision of public services, including health care. DRC covers one thirteenth of the entire African continent. It has Africa's fourth-largest population, estimated at over 90 million, and is comprised of 40 ethnic groups and more than 400 tribes.³ To its peril, the country also possesses vast natural resources that have lured foreign interference, galvanized autocratic rule, and fueled vicious cycles of violence for generations. Within a fragmented and often dysfunctional system, committed public health advocates have continued to champion the health and human rights of the people of DRC.

The difficulties that the country faces today connect back to one of history's most brutal colonial regimes. Beginning in 1878, King Léopold II and Belgian colonizers subjugated the Congolese people into forced labor to extract ivory, rubber, and other resources.⁴ During their occupation, the colonizers killed as many as 10 million Congolese,⁵ approximately half of the country's population at the time. DRC gained independence in 1960, but foundational socio-political tensions persisted, challenging DRC's nascent national identity and central governance structure. From the outset, the country contended with intensive foreign interference, separatist movements, and power plays for control of extractive industries. Decades

of colonial suppression of Congolese higher education further complicated post-independence governance. As one historian noted, "At the end of the 1959-60 academic year, only 136 children completed secondary education. There were no Congolese doctors, no secondary school teachers, no army officers."⁶

During the first decades of independence, under the leadership of General Joseph-Désiré Mobutu (1965-1997) and Laurent-Désiré Kabila (1997-2001), DRC suffered from division, corruption, and mismanagement that decimated the economy and crippled the provision of health and social services. The chaos and volatile power dynamics of the period spiraled the continent into the First and Second Congo Wars (1996-2003). As many as 5 million Congolese lost their lives, largely due to malnutrition and a lack of access to health services.⁶⁻⁸

Following his father's assassination in 2001, Joseph Kabila emerged as DRC's post-war leader. In 2006 the country signed a new constitution and committed to a decentralized system of governance that would strengthen local ownership and accountability.^{9,10} During his tenure from 2001 to 2019, the country achieved strong economic growth¹¹ and introduced sweeping reforms within and beyond the health sector. However, efforts to deliver on these commitments have been hampered by recurrent socioeconomic and

humanitarian crises, among other factors. Underlying tensions continue to strain central governance in the capital city of Kinshasa, complicate decentralized leadership by provinces, and stoke ongoing conflicts in Central and Eastern DRC.⁶

These factors have a devastating impact on the health of the Congolese population. One study estimates that achieving the Sustainable Development Goal (SDG) targets for maternal and child mortality reduction could save 218,000 and 1,300,000 lives, respectively—which would place DRC ahead of all but two other countries in the world in terms of lives saved.¹² As of 2019, DRC ranks as the eleventh-lowest on the Human Development Index¹³ and as the world's fifth-most-fragile state, in large part due to sharp limitations in “basic state functions that serve the people.”¹⁴ While the country has achieved some gains over the last decades, health outcomes remain poor. Table 1 provides an overview of key child, maternal, and reproductive health indicators from the country's two most recent Demographic Health Surveys.^{15,16}

The government has estimated that only 35% of the population lives within 5km of a health facility.¹⁷ Geographic barriers in access to health care are compounded by economic factors. Almost 60%

of the world's one billion people living in extreme poverty come from five countries, including DRC.¹⁸ A recent assessment found that the average expenditure per outpatient health care visit in DRC was 6.7 USD, not including additional under-the-table payments solicited by some providers,¹⁹ yet an estimated 73% of the population subsists on less than 1.9 USD per day.¹¹ In 2011, the government estimated that 75% of the population was excluded from accessing public health services as a result of poverty.²⁰ Most Congolese must choose between treating illness and assuming extraordinary financial burden. Faced with this choice, only 20% of the population in DRC routinely uses health services.²¹

The insufficiency of health and other public services for people living in DRC is both a driver and result of the country's socioeconomic and development challenges. The majority of morbidity and mortality in DRC arise from conditions that can be readily prevented or treated at low cost and successfully delivered through community-based approaches. Consequently, community health worker (CHW) programs provide a promising opportunity for DRC to accelerate progress in improving health and development outcomes for its population.

TABLE 1: Various Health Indicators for DRC

INDICATORS	2007 (DHS)	2013-2014 (DHS)
Infant Mortality Rate (per 1,000 live births)	92	58
Under-Five Mortality Rate (per 1,000 live births)	148	104
Maternal Mortality Ratio (per 100,000 live births)	549	846
Children Fully Vaccinated	31%	45%
Children with Diarrhea Treated with ORS	31%	39%
Unmet Need for Family Planning	24.4%	27.7%
Skilled Birth Attendance	74.0%	80.1%
ANC 4+	47%	48%

Understanding the Community Health System in DRC

There is currently no national, full-scale CHW program in DRC. There are, however, various cadres and program-specific community health volunteers, most of which are known as *relais communautaires* or RECOs. These RECOs generally fall into one of three categories:

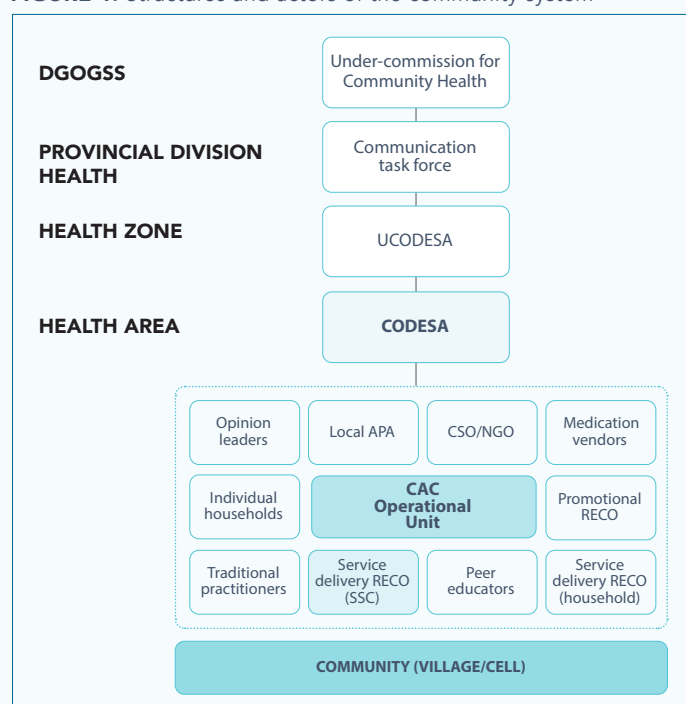
1. **Service delivery RECOs** who provide a minimum package of services—including integrated community case management (iCCM) for basic childhood diseases and contraceptives—and operate in units known as community care sites (*sites de soins communautaires* or SSCs).
2. **Promotional RECOs** who provide health education and promote health-seeking behaviors.
3. **Program-specific community health volunteers** who provide specific services related to particular diseases, like HIV/AIDS or tuberculosis.²²

The proliferation of RECOs across the country has been a largely NGO- and donor-driven effort, leading to significant fragmentation, incomplete coverage, and disparities in service provision and quality. Given the array of community health programs in DRC, it is difficult to generalize about their operational features, which are rarely described in policy documents. RECOs are unsalaried volunteers, though some receive minimal stipends, performance-based payments, training incentives, or in-kind compensation, often at the discretion of implementing partners.⁹ In recent years, the Congolese government has been increasingly working to develop policy frameworks to support, regulate, and begin to standardize community health.

Community health falls under the national leadership of the Ministry of Public Health (MSP) and the coordination of the provincial health division. The Health Zone Management Team is a critical entity responsible for planning and implementing community health, with the support of the Health Area Development Committee (CODESA) and Community Outreach Unit (CAC). These structures are responsible for engaging community members in a multi-sectoral range of social services.⁹ As shown in Figure 1, there are numerous other community-level health actors connected to each CAC, including traditional practitioners, peer educators, and medication vendors. But, in general, the community health discussion in DRC concerns RECOs.³

Both CODESAs, CACs, and other related community structures are sometimes referred to as community-based organizations in DRC. These structures are critical to DRC's community participation strategy, underpinning the country's current and envisioned community health system.

FIGURE 1: Structures and actors of the community system



DRC's Community Health Reform Foundations

Building on decades of country experience, leaders in DRC are increasingly promoting community health as a formal approach to improving health access and outcomes, and to achieving Universal Health Coverage (UHC). But it has been a long journey to this point: It has taken DRC many years to embrace community health as key to the health system's resilience against shocks like disease outbreaks, political insecurity, and natural disasters.

DRC's post-war health sector reforms focused first on rebuilding the national health system under government leadership, starting with facility-based services. Although community health was initially sidelined in sector-wide policy documents, DRC experienced a flourishing of vertical and NGO-run community health programs in the late 2000s. This period of experimentation both established the country as a leader in pioneering the scale-up of integrated community case management (iCCM) through service delivery RECOs and contributed to enduring fragmentation in community health. Efforts to meet the Millennium Development Goals (MDGs) led DRC to reevaluate the primacy of community health and community participation. This shift led to the landmark formal inclusion of community health in the National Health Development Plan (PNDS 2016-2020)²³ and the drafting of a national community participation strategy (PARTICOM),²⁴ opening up new opportunities to advance institutionalization of community health.

Before examining the efforts of recent years in greater depth, it is worthwhile to review previous health sector reforms in relation to community health. Over a series of cyclical reforms, leaders in DRC have periodically assessed health sector progress from ongoing implementation, monitoring and reviews, and channeled insights from these assessments into new reforms. In this way, DRC has moved progressively closer to building an effective, government-led health system that meets population needs in spite of steep geographic and financial barriers to care.

RECLAIMING COUNTRY LEADERSHIP & DEFINING A VISION FOR POST-WAR REFORM (2005)

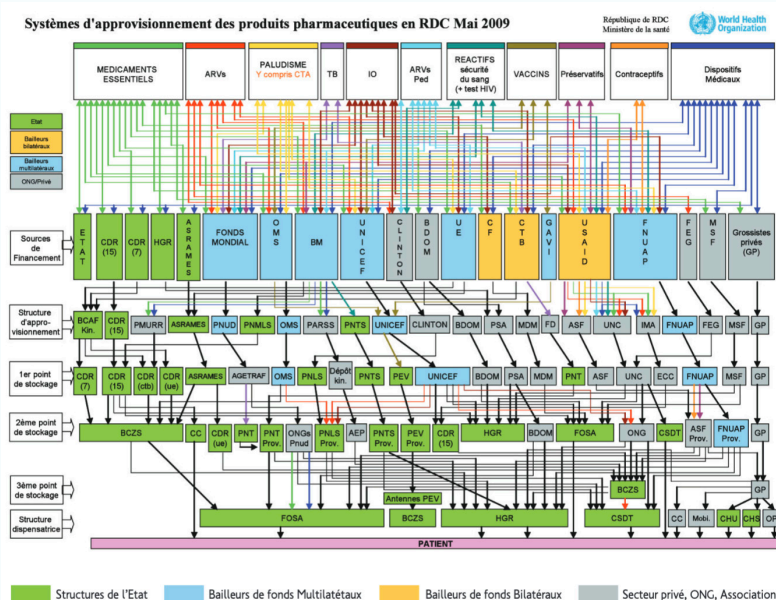
As DRC emerged from war and signed its new constitution in 2005, the government initiated broad-reaching public sector reforms to jump start reconstruction. The scale and complexity of the required reforms was sobering.

Despite the numerous management and socioeconomic challenges that the country faced after achieving independence, DRC initiated notable innovations in health systems reform in during the late 1970s and early 1980s. The country endorsed the 1978 Alma Ata Declaration of "Health for All"²⁵ and pioneered Africa's health district model as an integrated platform for primary health care delivery.¹⁰ However, during the protracted crises that followed, public sector financing and regulation broke down. By the early 2000s, DRC's health system, in the words of the Deputy Prime Minister for Reconstruction, "was only a distant historical reference."²⁶ The country depended almost entirely on external financing; and decades of verticalized, donor-driven interventions had steered the sector away from its history of integrated primary health care. The result was a highly inefficient system with disproportionate management costs, duplicative investment, convoluted coordination, poor service quality, and weak operations. DRC's health sector supply chain provides a powerful example of fragmentation and inefficiency.¹⁰ (See Figure 2.) In response, leaders established a multi-stakeholder coalition to pursue a "re-appropriation of health policy and governance by the MSP from external agencies that had been setting these policies over previous years."¹⁰ The government sought to identify the root causes of health system challenges and build consensus around a concrete, coordinated response. The result was a comprehensive reform strategy that redefined DRC's decentralized health system structure at the national, provincial, and operational levels.

In this first phase of reform, the priority was establishing the key pillars of the health system and facility-based health services. While this was largely to the exclusion of community health, it nonetheless established a health system framework on which later community health reforms could build. As

FIGURE 2: Structures and actors of the community system

A 2009 supply chain mapping exercise by the MSP and WHO revealed a dizzying, dysfunctional web of funding sources, procurement mechanisms, and distribution systems that wasted valuable resources and generated widespread stock-outs of essential medicines and supplies.



the government moved to enact its Health System Strengthening Strategy (SRSS), it called for partners to strengthen government leadership, procedures, and capacity; reduce fragmentation; and increase transparency.^{26,27} In line with these goals, the government established a single coordinating mechanism, the National Health Sector Steering Committee (CNP-SS), and associated platforms to improve transparency and management of external aid. In subsequent years, these reforms would drastically improve health sector efficiency and aid effectiveness.¹⁰

SIDESTEPING INITIAL RESISTANCE TO COMMUNITY HEALTH (2005-2010)

While these landmark reforms addressed many of the country's most foundational and pressing health sector issues, they left others unresolved. The question of how to extend health services to communities emerged as a point of contention.

The SRSS expressed concerns about community health worker approaches, citing them as "not always necessary," "often harmful," and having

been introduced at the "instigation of certain financial partners."²⁶ Despite these harsh critiques, the SRSS remained conspicuously silent on what the country's approach to community health should be, opening the door to continued fragmentation by partner, disease area, and geographic region. These tensions and unresolved issues persist in DRC's health system today and underlie challenges in establishing a unified vision for community health systems reform.

Though high-level health sector policies and plans did not institutionalize community health, neither did they prohibit such approaches. Some actors within government circumvented opposition to engage partners in community health pilot programs in areas such as child health, family planning, malaria, HIV, and TB.³ Perhaps the best-documented example comes from the evolution of integrated community case management of childhood illnesses (iCCM) programming in DRC. These experiences have been extensively described in a number of analyses,²⁸⁻³² and key lessons are summarized below.

FOUNDATIONS FOR REFORM - EARLY ICCM ADVOCACY AND IMPLEMENTATION IN DRC

Despite criticism of community health mounted in the SRSS, the MSP and its partners created avenues for piloting iCCM starting in 2005 under the Implementation Guidelines for Community Care Sites (*Guide de Mise en œuvre pour les Sites de Soins Communautaires 2007*).

DRC's iCCM approach, still active today, upgrades health promotion RECOs (*relais promotionnels*) to act as service delivery RECOs (*relais prestataires*). These service delivery RECOs are based at SSCs. While described as "sites," SSCs are not expected to be physical buildings. In addition to their previous responsibilities, service delivery RECOs provide iCCM services to communities more than 5km from the nearest health facility or otherwise inaccessible due to natural barriers. They receive supervision from head nurses (*infirmiers titulaires*) based at the nearest health center (*centre de santé*). Service delivery RECOs receive further support from community engagement structures at the community and facility levels.

In 2007, the incoming Minister of Health drew attention to the fact that 80% of child deaths in DRC happened in the home, without the child ever reaching a health facility. Based on early pilot evidence, he called for the country to reinforce and scale up community-based approaches to health care, including the scale-up of iCCM. However, this backing was not translated to sector-wide policies and plans.

Nevertheless, by 2017, the MSP and its partners had successfully introduced 6,968 SSCs and progressively expanded the iCCM service delivery package. These SSCs covered 402 out of 461 eligible Health Zones across all 26 provinces, though not with full coverage. Studies demonstrated that iCCM significantly improved health access and outcomes in supported communities. However, evaluations have also revealed significant fragmentation in approaches and variation in service quality. Evaluators have recommended that in order for the approach to reach its full potential, the MSP needs to resolve discrepancies in community health-related guidance and establish an enabling policy environment around community health.

MAINSTREAMING COMMUNITY HEALTH AS AN APPROACH TO MEET THE MDGS (2010-2015)

In 2010, the MSP kicked off a cycle of sector-wide reform. Community health advocates were hopeful that as the country gathered evidence from various community health pilot programs around the country, their recommendations would be integrated into sector-wide reforms. However, this would not be the case.

Community health language was almost entirely absent from the numerous new and revised policy documents that emerged at this time, including the first National Health Development Plan (*Plan National de Développement Sanitaire*

PNDS 2011-2015).^{17,20,33} To the extent that these documents mentioned community health, it was mostly tangentially and sometimes disparagingly. Furthermore, they elided central questions such as RECO health service packages. In sum, the policies borne of the 2010 sector-wide reform still did not offer a clear vision for how community health should operate in DRC.

However, the PNDS did leave the door open for government and its partners to pursue community health activities within Health Zones, at the discretion of the Health Zone Management Team (*Équipe Cadre de la Zone de Santé* or ECZS)¹⁷ In this context, actors within the MSP and their partners progressively developed a variety of community health initiatives across the

country. These efforts were accompanied by a proliferation of intervention-specific strategic plans, implementation standards, training manuals, and other normative documents. Different initiatives outlined expectations for the establishment and management of community structures and cadres across diverse program areas, from family planning and iCCM to nutrition and disease-specific vertical programs.^{3,9,28}

In the absence of strong national governance, these efforts were loosely coordinated at best. While the country benefited from short-term impact and developed rich implementation experience, these verticalized, fragmented, and partner-dependent approaches suffered from limited sustainability, quality assurance, and scale. Ultimately, these challenges have limited the potential of community health worker programs in DRC and contributed to the intractability of health problems faced by the population.³

Fortunately, persistent gaps in access to health services and performance relative to key health and development targets did not go unnoticed. As the country progressed through the 2011-2015 policy period, it became increasingly clear that the country was not on track to meet the Millennium Development Goals and other health sector targets. A series of health and development surveys, including the 2012 Enquête 123³⁴ and the

DHS 2013-2014,¹⁶ revealed stark inequities and shortcomings. The MSP used this data as a basis for a mid-term evaluation of the approaches laid out in the PNDS 2011-2015.

Through the mid-term evaluation, the Ministry found that the policies' lack of emphasis on community health was central to many of health sector's challenges and pursued corrective action. The health sector's flagship mid-term reform effort was the Acceleration Framework for Achieving MDGs 4 and 5 (*Cadre d'Accélération pour atteindre les Objectifs OMD 4&5* or CAO 4&5) detailed in below.³⁰ The CAO 4&5 achieved impressive reductions in child and maternal mortality in intervention areas, supported strong, multi-sectoral community mobilization, and set DRC on a more positive trajectory. However, it ultimately came too late for the country to achieve its immediate objective of achieving MDGs 4&5. An evaluation of CAO 4&5 drew attention to familiar challenges, such as health system weaknesses, fragmentation of partner approaches, reliance on parallel systems (e.g., for supply chain), and a lack of governmental commitment to sustain or further scale the approach. The evaluation specifically cautioned that the approach, and community health more broadly, lacked sufficient "institutional anchoring" within the MSP, dimming prospects for long-term viability and impact.³⁰

COMMUNITY HEALTH AND THE ACCELERATION FRAMEWORK FOR ACHIEVING MDGS 4 & 5

In 2013, DRC adopted CAO 4&5 with funding from the World Bank, Canada, Global Fund, GAVI, Sweden, EU, USAID, and UNICEF. CAO 4&5 became the country's flagship MDG program and ultimately reached 44 out of the country's 515 health zones. Its primary strategy was the distribution of "family kits" for management of childhood illness and promotion of facility-based delivery. Kit distribution was complemented by 1) strengthening community engagement and health promotion through community structures (CAC and CODESA) and improving management of SSCs; 2) coupling performance-based financing with capacity building of health providers; and 3) enhancing monitoring and evaluation. Reflective of tension across the community health space, approaches for distribution of child health kits differed between CAO 4&5 lead implementers, namely MSH and UNICEF. While MSH focused on reinforcing and distributing IMCI kits through SSCs, UNICEF targeted distribution directly to families. A comparative evaluation revealed that MSH's approach was more effective and added value by concurrently strengthening the community health system.

REPRIORITIZING COMMUNITY HEALTH AND PARTICIPATION IN THE SDG ERA (2015 ONWARD)

Based on these experiences, DRC came to attribute many of its persistent health sector challenges to weaknesses in community health systems and services, as well as community participation more broadly. Recognizing the promise of community health and the need for improved community health governance, the MSP sought, for the first time, to explicitly integrate community health into the PNDS. The PNDS 2016-2020 was the first sector-wide plan to positively recognize ongoing community health implementation in the country, a major milestone for community health institutionalization:

“The community is already playing a role in improving access to primary health care for children under five years of age through the pilot experience of community care sites.”²³

In 2015, at the time of the drafting of the PNDS 2016-2020, DRC was undertaking broad-reaching reforms, including advancing decentralization, further dividing the country from 11 to 26 provinces, and aligning new sectoral plans with the country’s core National Growth and Poverty Reduction Strategy (DSCR).^{23,35,36} The government considered effective community participation critical to the success of these reforms. In the absence of a concrete, unified strategy for

community participation, leaders feared that the fragmentation and poor performance of existing community participation approaches across different sectors would impede the reform efforts.²⁴ The MSP’s Primary Health Care Directorate, therefore, led a cross-sectoral process to develop the 2016 Strategic Framework for Community Participation in DRC (PARTICOM).²⁴

The PARTICOM strategy laid out priorities and activities to enhance community participation, describing community empowerment as key to addressing social determinants of health and spurring grassroots development. Critically, PARTICOM set national standards for the formation and function of community structures that underpin community health, like the CODESAs and CACs, thus anchoring all community participation activities in DRC. Refer to Figure 1 for a depiction of how these community structures oversee RECOs.²⁴

Together, PNDS and PARTICOM are critical milestones in DRC’s community health reform journey. As one profile notes, they have “reoriented the health system to increase the role of the community in health care delivery as a way to improve accountability and sustainability and better reach underserved populations.”⁹ Although they laid the foundation for future community health reform and institutionalization efforts, these documents did not resolve persistent challenges with fragmentation, lack of standardization, and poor coordination in community health. These concerns would need to be addressed through further reform efforts.

Institutionalization Challenges in DRC

The previous section demonstrates the immense progress that has been made over the last decades to place community-based primary health care at the center of DRC's health and development agenda. However, the country has faced persistent challenges in moving from policy development to practice in the health sector. Without addressing these barriers to effective implementation, it is unlikely that DRC will accomplish its vision of community health institutionalization: a coherent, community-based system that is aligned across all policy documents and functions seamlessly.

The preface of DRC's 2016-2020 National Health Development Plan (PNDS) lauds "the coherence and relevance of the recommended actions" of the previous health plan, reflecting strengths in the policy and program design phase.²³ Despite these strengths, the policy's rollout was hampered by insufficient mobilization of resources and program support. Gaps in program management and governance hindered the implementation that did take place. As the assessment explains, "lack of appropriate supervision and structured follow-up measures for its implementation at all levels" was a factor in the policy's failures.²³ Similar sentiments are echoed across retrospective evaluations of numerous national policies and plans of the past decade, reflecting systemic challenges in fully instituting reform.

New opportunities for community health institutionalization emerged around 2015 with the launch of the new PNDS and the PARTICOM strategy. Before examining DRC's advances in this most recent cycle of community health reform, however, this section analyzes the gaps in the institutionalization process leading up to this pivotal moment.

The community health systems reform cycle is a useful entry point to understanding the challenges faced in past reforms. Learning from pitfalls in previous reform cycles can help stakeholders set community health in DRC on a new trajectory towards institutionalization.





PROBLEM PRIORITIZATION

In the SDG era, DRC prioritized community health, explicitly integrating it into sectoral documents like the PNDS. In response to continual health shortcomings, the country recognized both the opportunity that community health approaches provide and the need for improved governance of community health programs in DRC. The resulting inclusion of community health in the 2016-2020 PNDS and 2016 PARTICOM strategy created an enabling environment for policy advancement, opening a window for a new reform cycle.

While reform processes in DRC typically include detailed situational assessments that allow leaders to identify and prioritize problems, at the time when PNDS and PARTICOM were developed, no such analysis of community health had been conducted.³ Evaluations from DRC's flagship MDG program (CAO 4 & 5) drew attention to familiar challenges, such as a lack of commitment to sustaining or further scaling the program, overall health system weaknesses, fragmentation of partner approaches and reliance on parallel systems (e.g., for supply chain).³⁰ However, without a full national situational assessment of community health in DRC, stakeholders and partners lacked data on which to build advocacy, allocate investments, or make programmatic decisions at a macro level.



COALITION BUILDING AND SOLUTION GATHERING

The MSP has shown strong leadership in aligning international development partners around the PNDS, presenting a comprehensive vision and strategy for the health sector.³⁷ By generating domestic consensus across and beyond the MSP on health sector reform aims, health authorities built stronger trust and collaboration with partners.¹⁰ Within the health sector strategy, specific measures could be tested, improved, redesigned, and adapted.

This coherence in the overall health sector vision, however, did not immediately translate to community health. The challenges of aligning the proliferation of community health partners persisted.³ Remnants of longstanding disregard for community health lingered among key stakeholders, borne of experiences of fragmentation and verticalization. In a context of decentralized governance and little direct guidance on community health implementation, many operational questions remained unanswered and contested among partners.⁹

Fragmentation persists in the context of weak governance and in the absence of a coalition of government, funder, and partner stakeholders to carry reforms forward in a unified manner. To the extent that reform efforts have been successful in DRC in the past, they are often within a specific technical area and not effectively integrated or coordinated with simultaneous efforts in other areas. Actors within and outside of the MSP have successfully advocated for programs with community health components, such as iCCM, to be tested and scaled.²⁸ However, these programs have remained standalone, vertical projects that lack full policy integration into the broader health sector plans. Indeed, many promising innovations do not translate to policy revisions or widespread adoption.



DESIGN

The 2016-2020 PNDS and the PARTICOM strategy both represented important openings for community health, but they did not fully establish the operational clarity and guidance needed. Overall, DRC has generated abundant national guidance for the health sector, vertical disease programs with community health components, and specific community health interventions. While these policies and plans may be well-designed in isolation, the challenge lies in their integration. Community health cadres, including RECOs, which cut across different health areas,

are generally not integrated into vertical health policies.³ Implementation guidance documents often “contain fewer details about RECOs, such as the number needed in the country and the processes by which they are supported, like training and supervision. Policies specify neither how RECOs access supplies nor how they interact with other community health providers and facility-based health workers.”⁹ This lack of integration of community health at the design stage of various programs has impeded the identification of gaps or areas of inconsistency. There is, therefore, incoherence between different documents, which has contributed to confusion at the sub-national level and fragmented implementation.

READINESS

Regardless of the merits of the national policy and program guidance that has been generated, these documents have not been sufficiently disseminated. Nor have stakeholders at the national and sub-national levels been sufficiently oriented to any shifts in their roles and responsibilities.^{9,25} Even when such mobilization does occur, it can present inconsistent recommendations that partners, MSP managers, and service delivery providers at the provincial, zonal, health center, and community levels are left to disentangle.

Resource mobilization has also been a significant weakness within DRC’s health sector, including in the area of community health. Until recent years, DRC has consistently allocated less than 5% of the national budget to health, significantly less than the 15% that African heads of state, including DRC, committed at Abuja.³⁸ To make matters worse, this allocation “does not take into account the priorities of the sector” and on average only 70% of these funds have been disbursed.¹⁷ This systematic under-resourcing of the health sector—combined with a disconnect between resources and established policies, plans, and priorities—has generated massive gaps.

Poor resource mobilization at the national level creates an environment ripe for fragmentation and verticalized programming as NGOs and external partners attempt to fill gaps. The inefficiencies generated by this fragmentation and poor coordination of external financing only worsen the situation. These funding gaps have real impact on the quality of community health implementation. For instance, there is broad consensus across community health stakeholders that DRC’s volunteer model for RECOs creates challenges in RECO motivation, retention, availability for meetings, reporting rates, and service delivery.^{3,39} There is no agreement, however, on how to address this challenge: The notion that DRC could mobilize sufficient resources to afford a paid national cadre of CHWs is seen as highly unrealistic.

LAUNCH

At the time of the development of the foundational PARTICOM and 2016-2020 PNDS, accurate national data on community health coverage was not readily available. More recent analyses, however, have confirmed the impression that MSP policies were not sufficiently rolled out. A 2017 UNICEF assessment of community participation structures found that 46,797 Community Outreach Units (CAC) were installed, but only 30% of them could be classified as functional according to the country’s revitalization standards.³ Community engagement varied by province, and participation was mediated through multiple concurrent structures with varying levels of functionality. The revitalization process for community participation structures has stalled in the face of insufficient guidelines for orienting the members of the units.

A 2018 situational assessment of DRC’s community health³ noted that the exact coverage of the SSCs from which RECOs served hard-to-reach populations could not be calculated because the denominator was still poorly defined. However, the office coordinating Integrated Management

of Newborn and Childhood Illness estimated that DRC would need 21,299 SSCs for full coverage, of which the existing 6,968 SSCs represented only 33%. Between 56-78% of active RECOs had been trained in health promotional activities such as hand washing, hygiene practices, oral rehydration salt distribution, recognizing malaria danger signs and birth registration. Less than half of the trained and active RECOs had health education materials. This same assessment profiled 16 major operational community health activities (none of which achieved full national coverage) and several disease-specific community approaches.



GOVERNANCE, AND MANAGEMENT AND LEARNING

Governance of community health programs in DRC has been a major weakness, exacerbated by continued fragmentation among implementing partners and poor adherence to existing policies. Only in recent years, following the opening of 2016 reform opportunities, has a National Community Health Sub-Committee been established. While decentralization was instituted in DRC partly in

response to the country's vast size and with the intention of strengthening local governance and accountability, these structures are still relatively new. Provincial health divisions lack resources and systems needed to manage the health system, such as human resources, infrastructure, and logistics capacities.³² Historically, vertical programs would often bypass Health Zone Management Teams, leading to confusion, lack of coordination, duplication of efforts, and inefficient use of resources.²⁶ The innovations that these programs test and best practices they develop for community health are infrequently institutionalized without a clear channel to share them with stakeholders and systematically embed them across DRC's policy landscape.

In light of the gaps across all phases of the reform cycle, community health stakeholders sought to capture opportunities presented by the PNDS 2016-2020 and 2016 PARTICOM strategy as the country's health sector entered a new phase of implementation.

The ICH Investment as a Catalyst for Reform

The Objectives of the ICH Investment in DRC

While community participation and community health had long formed part of the health system in DRC, a lack of consistent normative documents and operational models hindered the scale and functionality of RECOs and community structures like CACs and CODESAs.³ As a result, approaches to community health and participation were highly divergent, complicating the MSP's management and governance efforts. The PNDS 2016-2020 and PARTICOM solidified many of DRC's policy and strategic orientations for community participation and the health system more broadly. However, as higher-level strategic documents, they did not fully articulate how updated standards for community participation would function within the health

system. They also stopped short of defining a national vision for delivery of community health services.

As part of a collection of efforts to address these gaps, in 2016 the MSP, USAID, and UNICEF introduced DRC's Integrating Community Health (ICH) program and selected Humana People to People Congo (HPP-Congo) as the implementing partner. The primary objective of the ICH investment in DRC was to develop a comprehensive, coherent, and replicable operational model to implement the community engagement standards set out in PNDS 2016-2020 and PARTICOM at the health zone, health center, and community levels.^{39,40}

DRC'S ICH INVESTMENT AT A GLANCE

PROJECT: Strengthening CHW Systems in Urban and Rural Congo

IMPLEMENTING PARTNER: Humana People to People–Congo

DATES: March 8, 2016–March 7, 2020 Amount: 549,437 USD

OBJECTIVES:

- Establish a tested and replicable model for community health worker training.
- Establish a replicable model to create stronger linkages between the community, the community health workers and the local health facility staff.
- Develop an experience-based program for increasing the capacity of community-based health organizations.

SCALE:

- 700 *Relais Communautaire* (RECO) *Promotionnel*¹ organized under 123 *Cellules d'Animation Communautaire* (CAC) and 11 CODEVs, reaching approximately 20,000 households

Geographic Focus:

- **Urban:** 6 Health Areas within the Health Zones of Kingabwa and Selembao
- **Rural:** 5 Health Areas within the Health Zone of Kasenga

The ICH project began with intensive stakeholder consultation and sensitization to ensure that the program followed established guidance. HPP-Congo partnered with government and communities to roll out MSP policies that had, until this point, remained largely untested in practice. In the spirit of the PARTICOM strategy, a critical goal in the program design was to reinforce community structures like the CODESAs and CACs.

HPP-Congo, in partnership with local and national government, oriented Ministry staff at the health zone and health center levels to the new policies and plans, and strengthened their capacity to support the community structures that would be activated through the program. They also engaged and built capacity of local community structures, in line with country priorities emphasizing community participation. Once these systems were established, the program mobilized health promotion RECOs and communities to address priority health issues such as WASH, malaria, maternal and neonatal health, nutrition, and HIV/AIDS.^{39–41}

While geographically constrained relative to DRC's vast scale, the ICH program intended to generate strategic learning and recommendations for the development of DRC's first Community Health Strategic Plan and other health sector reforms. The program also sought to develop specific recommendations for adapting the operational model to both rural and urban contexts. From the outset, the program also sought to link implementation to national level coordination and decision-making through advocacy workshops, annual learning exchanges, and representation on delegations for global conferences such as the 2017 Institutionalizing Community Health Conference in Johannesburg.⁴²

The integration of RECOs and community structures into the health system through the ICH program has led to increased use of existing health services and improved understanding of the community's role in promoting the health of its members.⁴⁰ It has also generated valuable recommendations for how MSP policies and plans can both be adapted and better translated into practice.

Reform Strategies and Milestones During the ICH Period

By 2016, DRC was at a promising moment for community health systems reform following the PNDS 2016-2020 and the 2016 PARTICOM launch. In the following years, community health stakeholders took active measures to both generate and capitalize on momentum for reform across a number of stages of the reform cycle. This section provides an analysis of key initiatives underway, using the community health systems reform cycle to frame these advances.

The ICH investment described above contributed to the reform progress of this period and as such will be discussed in greater depth through this section. Given the complex, expansive nature of community health reform, however, many other stakeholders were simultaneously pursuing parallel efforts that similarly contributed to the reform evolution, as will be similarly discussed. These efforts of community health advocates to advance reform are laying the foundations for stronger, more coherent national implementation in the future.

Over the past few years, DRC has made progress towards better understanding the country's community health landscape, building coalitions of key stakeholders, and defining priorities for investment. Though the ICH investment was a relatively small initiative in terms of reach, it contributed to stakeholder goals of rationalizing different policy documents and operationalizing the 2016-2020 PNDS and 2016 PARTICOM. These collective efforts of numerous community health stakeholders led to the landmark development of the country's first national Community Health Strategic Plan (CHSP).³ Furthermore, DRC's efforts to define investment priorities in partnership with the World Bank's Global Financing Facility (GFF) and the Community Health Roadmap facilitated country-driven resource mobilization.^{43,44} Finally, community health advocates have leveraged opportunities to increase political buy-in for the CHSP by weaving community health into DRC's

agendas to strengthen health system resilience in the face of the country's deadliest Ebola outbreak and to institute UHC.

It is important to note that the gaps described previously in the Institutionalization Challenges section are substantial and will not be overcome quickly or easily. In the DRC as in many other contexts, community health reform has not always taken a linear path through the reform cycle. The activities of recent years have primarily worked to strengthen earlier phases of the reform cycle even as implementation of community health continues, albeit in the fragmented and often imperfect ways described previously. Activities aimed at institutionalizing community health often performed multiple functions, like strengthening coalitions in the service of developing policy design foundations or mobilizing resources. To that end, such multivalent activities may appear in this narrative at multiple phases in the reform cycle, reflecting the ways in which they advance each phase.



PROBLEM PRIORITIZATION AND COALITION BUILDING

In the wake of the new 2016-2020 PNDS and the 2016 PARTICOM strategy, health officials in DRC worked to better understand the landscape of community health and align community health activities to the priorities laid out in these documents. UNICEF conducted a health system bottleneck analysis and situational assessment of PARTICOM approaches,^{3,45} the results of which informed two key activities that defined national priorities for the health sector: the development of a country Investment Case for the World Bank's GFF⁴³ and the drafting of DRC's first CHSP.³

The very process of defining priority health issues for these documents brought stakeholders together in ways that did not necessarily lead to a formal coalition, per se, but did require these key stakeholders to meet regularly and agree on national priorities.

CONVENING STAKEHOLDERS TO DEFINE GLOBAL FINANCING FACILITY INVESTMENT PRIORITIES

When the World Bank launched the GFF in 2015 to catalyze funding for country-led investment plans promoting women's, children's and adolescents' health, DRC was one of the first countries to engage in the new initiative.⁴⁵ While the effort to draft DRC's Investment Case played a critical role in mobilizing resources for DRC's health sector, it also brought together stakeholders to align on national priorities.

In partnership with the GFF, the government of DRC assembled a multisectoral and multidisciplinary team of stakeholders from the ministries of health, budget, planning, and the interior, the Prime Minister's Office, civil society, and partners (e.g., WHO, UNICEF, UNFPA, World Bank, and USAID).⁴³ The MSP took the lead in defining reproductive and primary health care priorities in partnership with representatives from civil society and in line with the PNDS. DRC's Child Health Working Group⁴³—composed of all technical ministry departments involved in child health and relevant government partners—played a key advocacy role in determining resource allocation in the Investment Case.

The Investment Case ultimately prioritized twelve interventions to address the main determinants of child and maternal mortality and systemic bottlenecks. Importantly, it highlighted community approaches as a critical delivery mechanism for priority health services and included the strengthening of community participation and community-based health service delivery as an investment priority in its own right.⁴³

LAYING FOUNDATIONS FOR THE COMMUNITY HEALTH STRATEGIC PLAN

The CHSP was a groundbreaking milestone in DRC's community health institutionalization process. It achieved two goals: 1) to assess the community health landscape in DRC, and 2) to set a strategic direction for the operationalization of community health efforts in line with the revised PNDS 2016-2020 and PARTICOM.

In its SWOT analysis of the country's community health ecosystem, the CHSP reveals both promising indications of community health's progress and areas of concern.³ On the one hand, existing networks of RECOs, CACs, and CODESAs—along with guidance documents, training modules, and other resources—lay a strong foundation for the country's community health system. Health centers that benefited from the involvement of community participation structures—the CACs and CODESAs—reported a significant improvement in service uptake, demonstrating the value of community engagement to the health sector and validating DRC's approach of targeting community health improvement through these structures. On the other hand, the SWOT analysis also found stark gaps: unacceptably low coverage rates of community health interventions and of revitalized CODESAs, lack of standardization in implementation, and extensive quality problems.

To develop the CHSP, community health leaders, including the Director of Community Health in the Primary Health Care Directorate of MSP, convened a coalition of community stakeholders as well as technical and financial partners. They created the CHSP through information-gathering and consultation meetings, workshops to draft portions of the strategy, working sessions with the MSP, and field visits.³ Through the ICH investment, HPP-Congo held national workshops to facilitate learning and exchange among community health partners, which helped inform the CHSP. The 2017 Institutionalizing Community Health Conference in Johannesburg was also a critical milestone for the CHSP development, in which a high-level delegation from DRC took part in collective learning sessions with other country delegations and developed a country action plan to carry institutional reform forward.⁴²

The CHSP team took a deliberately participatory approach, as explained in the document itself: "Systematic consensus building has been the main mode of decision-making."³ Engaging stakeholders in this participatory manner has increased buy-in for the CHSP, even in the complex and fragmented context of DRC. The loose coalition that came together to develop and validate the CHSP has

since advocated for its integration with other health sector priorities, including the recently revised PNDS (which now covers 2019-2022). Given the role that this document plays as a critical linchpin in the institutionalization of community health, there is a concrete opportunity for more formal coalition-building to arise among the stakeholders involved in its development and promotion.



SOLUTION GATHERING AND DESIGN

The vision for community health institutionalization in DRC's current reform cycle is arguably to develop a coherent system of policies that function seamlessly together to enable effective implementation across the country. This vision hinges on a solid policy platform and alignment of community health practices across different policy documents. The launch of the 2016-2020 PNDS and PARTICOM strategy shifted the policy landscape, opening new opportunities to center community health. In order to secure the place of community health and improve the effectiveness of its implementation in future policy documents, there was a need to identify operational challenges under the new policy regime and identify solutions. The ICH investment contributed to this effort.

TESTING POLICY SOLUTIONS THROUGH THE ICH INVESTMENT

Through the ICH investment, HPP-Congo tested an operational model to carry forward the community engagement standards set out in the 2016-2020 PNDS and the PARTICOM strategy at the zonal, health center and community levels.³⁹⁻⁴² This trial run of the new policies in the context of community health identified points of conflict and potential barriers to widespread scale-up, and tested solutions to inform future policy design and roll-out. Specific areas that were tested included:

- Adaptations to CHW training and support materials to suit local context
- Linkages between the community, the community health workers, and the local health facility staff

- Alterations to program approach for urban and rural contexts
- Support to communities to be active agents in promoting their own health and achieving UHC

Across DRC, insufficient coverage of high-impact community-based health services continues to be a major health system weakness and is expected to grow worse in the face of a steep population growth. Together with local health authorities and MSP, HPP-Congo tested strategies to improve implementation within existing policy frameworks and identified creative solutions, including:

Literacy and numeracy training: DRC's national selection criteria for RECOs include minimum literacy levels in order to complete tasks such as the completion of written reporting forms. Putting this requirement into practice, however, narrowed the pool of applicants willing to take on a volunteer position, and often precluded candidates—in many cases women—that were most acceptable to community members. In some rural communities, there were no qualified candidates available at all when HPP-Congo launched recruitment. Historically, other initiatives had either recruited some candidates that were motivated to be RECOs but did not meet these minimum requirements or found themselves forced to recruit candidates that were literate but uninterested in being RECOs. These latter candidates were more likely to abandon their posts for paid employment, particularly in urban areas, and less likely to be trusted by the community.³

To avoid having to exclude motivated and trusted candidates on the basis of their literacy level, HPP-Congo worked with MSP and local authorities to introduce a literacy program to complement RECO recruitment. The six-month program built the reading, writing, and math skills necessary for RECOs to fulfill their required literacy- and numeracy-dependent tasks. HPP-Congo also developed better fit-for-purpose education materials and reporting tools with pictures and local-language text, to replace the inaccessible French language materials in use. The program allowed highly motivated community members who otherwise would have been excluded to enlist, and existing RECOs who had been recruited under programs that did not follow the literacy

requirement to retain their positions. Managers and supervisors observed a drastic improvement in RECO motivation, retention, and performance as a result of these adjustments. Furthermore, the program recruited more women than men. In this way, the ICH investment bypassed reform bottlenecks to develop a solution that both adheres to existing policy and addresses the problems the policy creates.

Defining catchment areas: HPP-Congo discovered that not only were there not enough RECOs but that most RECOs did not have defined coverage areas. Thanks to fragmented community health services, RECO catchment areas varied based on the activities they were conducting. As a result, RECOs could not track whether they actually reached all families, leading to some households falling through the cracks. This in turn created frictions between the RECOs and the community, especially in urban areas, where the problem was particularly acute.

In response to this challenge, HPP-Congo worked with RECOs and local authorities to map communities and define work areas for each RECO with specific households to cover. Over the course of the project, RECOs were better able to build trust by engaging with their assigned households and following up with families they had referred to the clinic for care. Not only did this shift help with ensuring coverage rates, it also increased community engagement and uptake of facility-based health services, an important objective of the CHSP.

Strengthening decentralized governance:

Vertical programs frequently bypass Health Zone Management Teams, engaging directly with communities. As a result, these teams often have an unclear picture of what activities are underway in which communities and by which RECOs. Contrary to the government's vision of streamlined, integrated health management through the Health Zones, there are many different RECOs doing different activities in a fragmented and inefficient fashion. The ICH Investment set out to demonstrate a different model of collaboration, prioritizing the Health Zone Management Team as the main program implementation partner. HPP-Congo held seminars to sensitize the local

authorities on the new policy documents, engaged the Health Zone Management Team in co-facilitation of trainings, campaigns and meetings, and shared quarterly action plans and reports to enhance transparency and ownership. These efforts led to increased involvement in community health by local authorities, allowing them greater visibility into and ownership of these activities.

DRC'S FIRST NATIONAL COMMUNITY HEALTH STRATEGIC PLAN

While it remains to be seen if the solutions tested under the ICH project will be inscribed in policy in the long term, a short-term opportunity for influence emerged in the drafting of DRC's first national strategic plan solely dedicated to community health. A milestone document, the Community Health Strategic Plan (CHSP) provided opportunities for problem prioritization and coalition building in DRC's community health ecosystem. It also offered, for the first time, a unified policy vision for community health.

The CHSP defines the pillars of a minimum package of services for community health, including home visits, civil registration data collection, iCCM services, referral for care, disease surveillance, and education to promote basic health practices including vaccine uptake.³ It identifies the CODESAs and CACs as the primary structures used to strengthen community health services, in line with the PARTICOM strategy. Community health is thus founded in community engagement. The CHSP is intentional about building on existing structures, platforms, and policy documents that relate to community health while insisting on the role of community interventions in achieving national health objectives defined in the PNDS.

A broad range of stakeholders within and beyond government, including those involved in the ICH investment, are increasingly recognizing the need for community health reforms that are based on evidence and experience, and are not only based on evidence and experience but also function seamlessly as a coherent system. These actors have identified a number of areas of existing policies and models for practice—for example, the selection, training, and remuneration of RECOs and community engagement—where inconsistency

across policies can at best create confusion and at worst generate significant inefficiencies and gaps in performance. The intention to reduce costs with a volunteer work force raised challenges in terms of attracting RECOs with the educational skills to meet program requirements; prioritizing candidates that would be most acceptable to the community across other dimensions; and motivating and retaining RECOs and members of community structures. To achieve results, the program needed to invest significant resources in literacy training as well as recruitment and pre-service training of larger numbers of new RECOs and members of CACs and CODESAs to replace those who had dropped out.



READINESS AND BUILDING POLITICAL WILL

The increasing importance placed on community health and renewal of community health coordination created opportunities for the country to more clearly define its priorities. This prioritization, in turn, has facilitated more country-driven mobilization and alignment of resources. Strong examples of this come from the country's leadership of the Global Financing Facility (GFF) Investment Case⁴³ and the Community Health Roadmap.⁴⁴ A critical component of readying the CHSP for national scale-up is securing greater political buy-in and support. Community health advocates have been strategic in mobilizing this support by linking community health to national agendas related to health system resilience and universal health care goals.

MOBILIZING RESOURCES THROUGH THE GFF INVESTMENT CASE

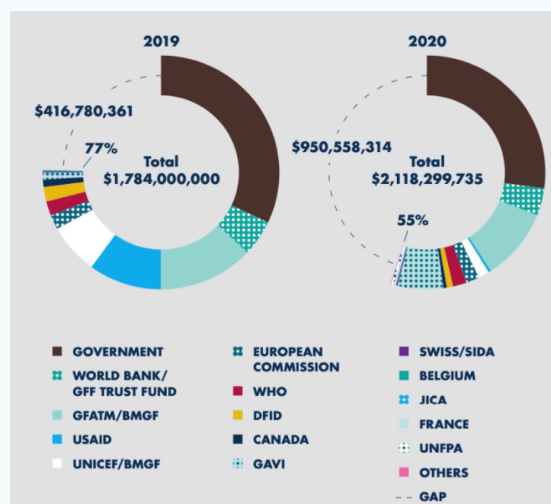
The GFF Investment Case was developed as a tool for mobilizing resources for primary health care priorities. The fact that community-based approaches were incorporated as a priority pillar of the Investment Case speaks to the efforts of community health advocates. While the Investment Case contributed to the problem prioritization and coalition building, as described previously, its primary goal was to estimate the cost of desired policies, map existing resources, and develop a convincing argument for donors and other investors to bridge funding gaps.

To that end, the World Health Organization (WHO) supported the costing of health sector priorities included in the Investment Case.⁴⁵ The GFF Secretariat assisted a resource mapping exercise to analyze expected funding over the following five years across the 14 provinces prioritized in the Investment Case. At the time of the Investment Case development, resource mapping revealed that DRC lacked approximately 844 million USD or 32% of the Investment Framework budget to fully implement its desired activities, with some provinces more underfunded than others.⁴³

The GFF combined an upfront investment in the immediate health needs with longer-term capacity building to address DRC's funding gaps.³⁸ As of 2020, the GFF was providing 60 million USD in grant financing that leveraged 340 million USD from the World Bank's International Development Association, as well as additional funding from USAID, Gavi and the Global Fund. GFF supported the launch of a dedicated health financing unit for financial management and planning; the implementation of program-based budgeting to help align resources to the national plan; the introduction of strategies to reduce donor fragmentation; and the establishment of a regular resource mapping process.³⁸ (See Figure 3.) In light of challenges linked to budget execution, the Investment Case set a target to support DRC in improving from 63% budget execution to 80%.⁴³ To that end, the GFF assisted with a bottleneck analysis at the central and decentralized level and established an inter-ministerial committee to monitor budget execution.

Because DRC adopted the Investment Case priorities in the national health planning and budgeting process, the MSP and its partners have been able to identify funding gaps and advocate for more resources, including domestic resources. According to the GFF, DRC's share of the government budget allocated to health increased from 6.9% in 2016 to 10% in 2019.³⁸ While the government's relative contribution to the PNDS budget decreased between 2019 and 2020 (as shown in Figure 3), the small absolute increase in government resource mobilization represents progress.

FIGURE 3: Draft results of the 2019 and 2020 resource mapping exercises show that the funding gap increased between 2019 and 2020, in part due to higher costs forecasted for 2020 and in part due to COVID-19.



COMMUNITY HEALTH ROADMAP

In 2019, MSP officials worked with the Community Health Roadmap team, a collaboration between multilateral and bilateral donors, private funders, and global health organizations that aims to attract new resources to community health in priority countries. A partnership between USAID, the World Bank, the WHO, the Bill & Melinda Gates Foundation, The Rockefeller Foundation, and UNICEF, the group worked with DRC's government and key partners to document existing country priorities for community health. By concisely presenting community health-specific objectives and funding gaps, the Community Health Roadmap aims to mobilize funding, reduce fragmentation, identify opportunities to improve program design, and encourage political commitment to community health.

In DRC, stakeholders identified some of the country's key community health goals as: achieving greater coverage through the scale-up of RECOs, stabilizing the RECO workforce, improving linkages to the primary health care system, strengthening CACs to ensure their functionality, reinforcing the supply chain; and establishing a community health information system.⁴⁴ The Roadmap also identified

a need for national-level coordination mechanisms for community health and a more enabling political, legal, and public affairs governance environment for RECO rights and duties.

Critically, the Roadmap's assessment of DRC's funding gaps was sobering. Out of a forecasted 95 million USD to scale up and implement the national community health strategy from 2018/19-2021/22, over half of which (57%) would go to RECO allowances, only about 2.1 million USD was committed and finalized from donors and DRC government.⁴⁴

COMMUNITY HEALTH FOR EPIDEMIC RESPONSE AND RESILIENCE

One of the major factors raising the profile of community health as a priority in DRC in recent years has been the country's experiences with Ebola. The Ebola virus is endemic in DRC, and in the last 40 years the country has suffered 11 outbreaks of the disease. The majority of these flare-ups were contained to isolated rural villages⁴⁶ and controlled relatively quickly. In August 2018, however, DRC's tenth outbreak emerged and became what now stands as one of the largest Ebola outbreaks in history, second only to the 2014-2016 epidemic in West Africa. While cases were largely concentrated in North Kivu, a province marked by insecurity, the disease also reached neighboring provinces of Ituri and South Kivu and crossed into Uganda. By the time the WHO declared the outbreak over on June 25, 2020, DRC had recorded 3,470 probable and confirmed cases, and 2,287 deaths.⁴⁷ Even before the end of the 2018-2020 outbreak, an eleventh unrelated outbreak had begun in Equateur province with 130 cases and 55 deaths by the time it was declared to be over on November 18, 2020.⁴⁸ These outbreaks have refocused attention in DRC on the need for resilient health systems that are capable of rapidly detecting and responding to outbreaks. The Ebola response has mobilized high-level political will to develop sustainable emergency response systems and stronger health systems. What is remarkable is the degree to which community health has taken center stage in these efforts.

As the tenth Ebola outbreak progressed and caused unprecedented challenges in its containment—not

least because the outbreak occurred in areas with ongoing conflict and eroded trust between the population and government authorities—the role of community structures and RECOs came to the fore. Actors across DRC and international agencies grew to recognize that initial failures to contain the outbreak were linked to insufficient community engagement, trust, and access for remote populations.^{49,50} As a result of these shortcomings, community members refused to participate in contact tracing or hid sick family members, and Ebola response teams faced sometimes deadly violence.

Over time, response strategies increasingly prioritized objectives related to community participation. The fourth integrated strategy, spanning July-December 2019, singled out community engagement as a key pillar of the Ebola response.⁵¹ The strategy calls for stakeholders to support communities to take ownership over the response through the implementation of existing community health and participation strategies. Specifically, Ebola response projects have invested in revitalizing CACs and CODESAs to support dialogue with community leaders. The national strategy established a target that at least 50% of alerts arise from CACs, demonstrating the critical role the government intends these existing community structures to play. In response to community resistance to Ebola containment activities, response actors in one affected Health Zone worked with communities to develop a “Key Principles of Engagement” document signed by community members and health workers to guide their interactions, build trust, and provide mutual accountability.⁵² Community members were engaged as active participants in the Ebola response, reflecting an evolution in their role in broader primary health care service delivery.

The recent Ebola outbreaks in DRC, together with the COVID-19 pandemic, has mobilized political will to build resilient health systems that are capable of rapidly detecting and responding to outbreaks. The infrastructure of community engagement mobilized to bring Ebola under control was not intended to be a short-term fix, but rather a long-term investment to buttress DRC's health system against future shocks. As noted by then-Minister of Health Dr. Oly Ilunga Kalenga at a high-level

meeting on DRC's tenth Ebola outbreak in July 2019, the outbreak was "a public health crisis that is occurring in an environment characterized by development challenges and deficiencies of the health system."⁵³ As a result, he said, those supporting the outbreak response needed to do so in partnership with existing institutions to avoid further fragmentation and parallel structures. Only by anchoring the Ebola response in the existing health system and strengthening the MSP would DRC be able to ensure the sustainability of the response investments, he insisted.⁵³

Stakeholders in DRC intended for investments in the community component of the Ebola response to not only support future outbreak needs but also reinforce the health sector response to everyday health crises. The July-December 2019 Integrated Ebola Strategy—the one that highlighted the specific role of community engagement—emphasized that such engagement needed to be holistic. By targeting community structures like the CAC, the strategy would factor in the epidemic as part of the many health and social issues facing communities.⁵¹ Political buy-in for this strategy of leveraging the community-based Ebola response to strengthen the broader long-term health system is far reaching: It includes President Tshisekedi, who has endorsed this approach since taking office in early 2019.

Given the frequent and often concurrent disease outbreaks—measles, cholera, and Yellow Fever²⁹—it is essential to reinforce primary health care and epidemiological surveillance services at the community level. The Ebola outbreaks highlighted this fact and generated political will that community health stakeholders can now leverage to promote policy institutionalization and resource mobilization for community health.

LEVERAGING UNIVERSAL HEALTH COVERAGE MOMENTUM AND POLITICAL TRANSITIONS

While working to institutionalize community health, DRC has also embraced a vision of UHC. In fact, UHC formed the backbone of the 2016-2020 PNDS, entitled "Towards Universal Health Coverage."²³

In 2016, DRC reaffirmed its membership as the International Health Partnership evolved into UHC2030, a coalition of countries and international development agencies committed to aligning resources and building capacity for UHC. At the

same time, the country launched its National Strategy for Universal Health Coverage 2017-2019. While the country has made some progress in aligning donors to this vision, the strategy has not made substantial impact at the sub-national level.³⁷ Critically, the effort to achieve UHC has mobilized political will from the top.

In December 2018, the country held presidential elections, leading to DRC's first peaceful transition of power since independence in 1960.⁵⁴ Former opposition leader and newly elected President Felix-Antoine Tshisekedi forged a coalition government and pledged to undertake sweeping changes to government policies. In 2019, President Tshisekedi appointed Dr. Eteni Longondo as the new Minister of Health, and both have expressed strong commitment to UHC. The President has continued to build momentum behind UHC by appointing a Special Advisor for UHC.⁵⁵ He has also shared his vision at critical meetings and conferences, such as the 2019 UN High-Level Meeting on UHC and a face-to-face meeting with the UN Secretary General.⁵⁶ While it remains to be seen how these commitments will translate into practice, there is reason to be optimistic that advocates can transform this political will into action.

Universal health coverage now stands at the forefront of DRC's national policies and strategies. But the country is unlikely to achieve UHC without workforce reform, including the scale-up of effective community health programming. Community health approaches are recognized as being central to bringing health services to remote communities and achieving health-related SDGs, including UHC.³² Given the political buy-in for UHC and its linkages with community health, there is currently a real opportunity to push forward health reforms. Community health leaders have, therefore, been strategic in syncing the validation of the Community Health Strategic Plan with the reframing of the PNDS 2019-2022—along with other concurrent political transitions. As a result, the new government is increasingly buying into the vision set out in the Community Health Strategic Plan. Achieving UHC through the scale-up of community health programming would be a victory not merely for community health advocates, but for all Congolese for whom health services are currently out of reach.

Opportunities and Next Steps

DRC is well-positioned to move forward on institutionalizing community health. Community health stakeholders in DRC are increasingly aligned around a vision of institutionalization in which community health and community participation policies are not only based on evidence and experience, but also function seamlessly as a coherent system. Building on the opportunities presented by the 2016-2019 PNDS and the PARTICOM strategy, community health advocates worked to develop the country's first Community Health Strategic Plan, a backbone document for further institutionalization efforts. With the recent establishment of a National Community Health Sub-Committee, DRC now has a platform for improved coordination of community health. Efforts to mobilize and align domestic and international resources to government priorities for health, including community health, are intended to help close DRC's funding gap to improve health outcomes. Finally, by linking the advancement of community health to UHC goals and the Ebola response, advocates for the institutionalization of a community-based approach can mobilize the type of political will needed to make lasting change.

The Community Health Systems Reform Cycle can help inform health advocates' next steps as they pursue current opportunities to better institutionalize community health.



PROBLEM PRIORITIZATION AND COALITION BUILDING

In light of the ongoing global COVID-19 pandemic, countries around the world are faced with the necessity of diverting attention and resources away from pre-existing priorities to respond to

COVID-19—even as the economic impact of the pandemic causes additional hardship and resource constraints. Still, there are opportunities for the pandemic to result in stronger community health systems. Much as DRC's experiences with Ebola refocused attention on community health, community health workers around the world are supporting COVID-19 response activities and protecting access to essential care. It remains to be seen whether community health advocates in DRC will be able to leverage global attention to public health to ensure that community health and UHC remain top priorities.

Such efforts are likely to be strengthened through the development of a strong coalition that could mobilize collective action. Given the role that the CHSP plays as a critical linchpin in the institutionalization of community health, there is a concrete opportunity for more formal coalition-building to arise among the stakeholders involved in its development and promotion. As a formal coalition, these stakeholders could continue to mobilize political will, resources, and innovative solutions to bolster community health. In particular, there are opportunities to link the institutionalization of community health with other national priorities, such as achieving UHC, strengthening epidemic response capacities and building health system resilience.



SOLUTION GATHERING, ASSESSMENT, AND POLICY DESIGN

In order to actually implement the vision and guidance outlined in the CHSP, various multisectoral stakeholders will need to revise or develop Annual Action plans with activities that

align with the CHSP.³ Similarly, vertical programs will need to adjust their policy documents to properly incorporate the community activities inscribed in the CHSP and to ensure that existing policies are harmonized with the CHSP. If these vertical programs and other implementing partners update existing national curriculum documents and integrate them into a national training process with national guidance on supervision, the community health system in DRC could be further standardized. Future policies and health sector planning documents, like the PNDS, will need to take not only the CHSP into account, but also learnings from the ICH project and other programs. Developing a channel by which program learnings can be systematically translated into policy adjustments will be a critical next step.



READINESS AND LAUNCH

DRC has set ambitious targets for scaling up its RECO workforce and strengthening the capacity of its community-based organizations, including the CACs and CODESAs. In support of these roll-out efforts, MSP should plan an intensive education and sensitization campaign with all stakeholders—in particular the sub-national governance bodies like the Health Zone Management Teams. Based on the experiences of the ICH project, there is a strong need to equip decentralized health authorities with the information they need to ensure effective implementation. There are also opportunities to incorporate learnings from the ICH project into the recruitment and training of RECOs, and capacity-building for CACs and CODESAs—all of which are activities that the MSP and partners will need to undertake in the coming years.

Furthermore, funding is needed to cover the costs of rolling out community health services nationwide. To the extent that the CHSP will be largely financed by external partners, these partners must align with the national vision set

out by the MSP. The GFF Investment Case and Community Health Roadmap are already helping to mobilize funding that aligns with national priorities, but there is a persistent funding gap. The government of DRC will also need to ensure that the share of the national budget allocated to health continues to grow at least to the 15% target of the Abuja agreement. That is, if DRC is to establish the nearly 3,500 additional Community Care Sites that the CHSP estimates are needed to cover 50% of population needs.³



GOVERNANCE, MANAGEMENT AND LEARNING

In DRC's context of decentralization, strengthening sub-national governance and management capacity is essential to ensuring the effective implementation of any program, including community health. The CHSP intends to coordinate activities across all health system levels, and recognizes that there is a risk of centralizing technical support at the national level, which could cause local authorities and communities to disengage.³ Because insufficient resource transfer from the central level to decentralized provincial leadership can impede effective governance and management, this is an issue that will need to be addressed in the coming years.⁵⁷ Community health in DRC is entwined with community empowerment, and priority is given to localizing authority through community-based organizations, Health Zone Management Teams and provincial management.

Future work to strengthen DRC's governance, management and learning will, therefore, need to include all levels of the health system—the national, provincial, district, sub-district, and community levels. In theory, each of these levels plays a role in collecting and analyzing data from RECOs. These governance structures often face operational and technical weaknesses in regularly reviewing data

and assessing its quality.⁵⁸ There is a reported lack of available data collection and compilation tools, capacity for data compilation, and infrastructure. Feedback mechanisms to incorporate data into system improvement are similarly weak.⁵⁸ Looking forward, it will be vital ensure that quality data is collected and informs operational decisions at every level of the health system.

One window of opportunity for enhancing program governance lies in recent efforts to better promote gender equity in the sharing of resources and responsibilities. The MSP has begun to implement gender sectoral units to promote gender mainstreaming at every level of the health system, including the community level. Recognizing both the critical importance of gender equality to achieving sustainable development goals and persistent challenges in reaching gender parity in leadership positions in DRC, the Ministry of Gender has instituted the creation of a gender unit in each Ministry at the national, provincial, and operational levels.⁵⁹ Within the MSP, these gender units are permanent structures with a mandate to monitor and evaluate gender mainstreaming in the administration's policies and programs. The gender units in provinces with USAID programming will promote women in decision-making at every level, including representation among the RECOs. This infrastructure will help build the capacity of Congolese institutions and communities to both provide high-quality health services and contribute to the promotion of equal rights between women and men.*

In Conclusion

The opportunity of the moment in DRC to institutionalize community health—which in itself bears immense opportunities to save lives—can hardly be overstated. After years of testing community health programs, such as iCCM, without institutionalizing a national approach, DRC has recently made impressive progress in enshrining community health in its health sector plans. The milestone national Community Health Strategic Plan represents a leap forward in institutionalizing community approaches, defining the pillars of a community approach, and outlining a vision for national implementation. As DRC works to harmonize the fragmented policies and implementation approaches that have proliferated over the past two decades, the ICH investment can offer helpful lessons in aligning community health with policy documents. Recent resource mobilization efforts that seek to align with national priorities have also highlighted the importance of community health, such as the GFF Investment Case and Community Health Roadmap. These documents clarify national priorities and serve as reference points for donors seeking to advance community health. Finally, it is crucial to recognize the importance of DRC's experiences with Ebola and its political will to achieve UHC. With this window of opportunity to mobilize high-level support for community health, there is reason for optimism among those who hope to see stronger health outcomes in DRC in the years to come.

* Insights in this paragraph were shared by Mme Emilia Ntumba of the Primary Health Care Directorate of the Ministry of Health.

References

1. World Health Organization. *WHO Guideline on Health Policy and System Support to Optimize Community Health Worker Programmes*. Geneva; 2018. <https://apps.who.int/iris/bitstream/handle/10665/275474/9789241550369-eng.pdf?ua=1>.
2. Chen N, Raghavan M, Albert J, et al. The Community Health Systems Reform Cycle: Strengthening the Integration of Community Health Worker Programs Through an Institutional Reform Perspective. *Glob Heal Sci Pract*. 2021;9(Supplement 1):S32-S46. doi:10.9745/ghsp-d-20-00429
3. Ministère de la Santé Publique. *Plan Stratégique de la Santé Communautaire en RDC 2019-2022*. Published 2018.
4. Gondola CD. *The History of Congo*. Westport, CT: Greenwood Publishing Group; 2002.
5. Hoschschild A. *King Leopold's Ghost: A Story of Greed, Terror, and Heroism in Colonial Africa*. New York: Mariner Books; 1998.
6. Meredith M. *The Fate of Africa: A History of the Continent Since Independence* (Revised and Updated). New York: PublicAffairs; 2011.
7. International Rescue Committee. *Mortality in the Democratic Republic of Congo: An ongoing crisis*. <https://www.rescue.org/report/mortality-democratic-republic-congo-ongoing-crisis>. Published May 2007.
8. NBC News and Associated Press. *Review of Congo war halves death toll*. http://www.nbcnews.com/id/34958903/ns/world_news-africa/t/review-congo-war-halves-death-toll/#.XvOP5ZNKjOQ. Published Jan 2010.
9. Devlin K, Egan KF, Pandit-Rajani T. *Community Health Systems Catalog Country Profile: Democratic Republic of Congo*. https://www.advancingpartners.org/sites/default/files/catalog/profiles/drc_chs_catalog_profile_0.pdf. Published July 2017.
10. Ntembwa HK, Van Lerberghe W. *Democratic Republic of the Congo: Improving Aid Coordination in the Health Sector*. https://www.who.int/health_financing/documents/Efficiency_health_systems_Congo/en/. Published Sept 2015.
11. World Bank. *Democratic Republic of Congo Overview*. <https://www.worldbank.org/en/country/drc/overview>. Last updated April 2021.
12. McArthur JW, Rasmussen K, Yamey G. How many lives are at stake? Assessing 2030 sustainable development goal trajectories for maternal and child health. *BMJ*. 2018;360. doi:10.1136/bmj.k373
13. United Nations Development Programme. *2019 Human Development Index Ranking | Human Development Reports*. <http://hdr.undp.org/en>.
14. The Fund for Peace. *Fragile States Index: Global Data* (2020). <https://fragilestatesindex.org/data/>.
15. Ministère du Plan, Ministère de la Santé, Macro International Inc. *Enquête Démographique et de Santé, République Démocratique du Congo 2007*. <https://dhsprogram.com/pubs/pdf/FR208/FR208.pdf>. Published Aug 2008.
16. Ministère du Plan et Suivi de la Mise en Œuvre de la Révolution de la Modernité, Ministère de la Santé Publique, MEASURE DHS, ICF International. *République Démocratique du Congo Deuxieme Enquête Démographique et de Santé (EDS-RDC II 2013-2014)*. <http://dhsprogram.com/pubs/pdf/FR300/FR300.pdf>. Published Sept 2014.
17. République Démocratique du Congo Ministère de la Santé Publique Secretariat General. *Plan National De Developpement Sanitaire PNDS 2011-2015*. Published March 2010.
18. World Health Organization. *Rapport OMD 2000-2015: Evaluation des progrès accomplis par la République Démocratique du Congo dans la réalisation des Objectifs du Millénaire pour le développement*. https://www.undp.org/content/dam/dem_rep_congo/docs/MDG/UNDP-CD-RNOMD%202015%20RDC.pdf. Published Sept 2015.
19. Laokri S, Soelaeman R, Hotchkiss DR. Assessing out-of-pocket expenditures for primary health care: How responsive is the Democratic Republic of Congo health system to providing financial risk protection? *BMC Health Serv Res*. 2018;18(1):1-19. doi:10.1186/s12913-018-3211-x
20. République Démocratique du Congo. *Volume 1: Document de la Stratégie de Croissance et de Réduction de la Pauvreté*. http://planificationfamiliale-rdc.net/docs/16_DocumentDeLaStrategieDeCroissanceEtReductionDeLaPauvrete2eGeneration_DSCR_2011_2015_Vol.1_Octobre2011.pdf. Published Aug 2011.

21. Dunia GMB. Implantation des sites de soins communautaires en république démocratique du congo: Consécration d'un double standard dans l'accès aux soins. *Pan Afr Med J.* 2013;14:158. doi:10.11604/pamj.2013.14.158.2003
22. Raven J, Wurie H, Idriss A, et al. How should community health workers in fragile contexts be supported: qualitative evidence from Sierra Leone, Liberia and Democratic Republic of Congo. *Hum Resour Health.* 2020;18:58. doi:10.1186/s12960-020-00494-8
23. Ministère de la Santé Publique. *Plan National De Development Sanitaire 2016-2020: Vers La Couverture Sanitaire Universelle.* <https://www.prb.org/wp-content/uploads/2020/06/RDC-Plan-National-de-Developpement-Sanitaire-2016-2020.pdf>. Published March 2016.
24. Ministère de la Santé Publique. *La Stratégie de Developpement de La Participation Communautaire en RDC.* Published 2016.
25. Ministère de la Santé. *Plan National de Développement Sanitaire recadré pour la période 2019-2022: Vers la Couverture Sanitaire Universelle.* https://santenews.info/wp-content/uploads/2020/04/PNDS-2019-2022_GOUVERNANCE.pdf. Published Nov 2018.
26. Ministère de la Santé. *Strategie De Renforcement Du Systeme De Sante*; 2006.
27. Ministère du Plan. *Document de Stratégie de Croissance et de Réduction de la Pauvreté de la 1ère génération 2007-2010 (Draft 2)*; 2006.
28. USAID Maternal and Child Integrated Program. *Prise en Charge Communautaire Intégrée de l'Enfant: Documentation des meilleures pratiques et des goulots d'étranglement à la mise en oeuvre du programme en République Démocratique du Congo.* https://www.mchip.net/sites/default/files/mchipfiles/DRCLongFrench_FINAL.pdf. Published Jan 2012.
29. USAID Maternal and Child Survival Program. *Review of Newborn Health Content in Integrated Management of Newborn and Childhood Illnesses and Integrated Community Case Management Training Materials and Job Aids in Seven Maternal and Child Survival Program Countries: Findings and Recommendations.* <https://www.mcsprogram.org/resource/review-of-newborn-health-content-in-integrated-management-of-newborn-and-childhood-illnesses-and-integrated-community-case-management-training-materials-and-job-aids-in-seven-maternal-and-child-surviv/>. Published Sept 2019.
30. UNICEF. *Évaluation sommative et formative du Cadre d'accélération des Objectifs du Millénaire pour le Développement (CAO) 4 & 5 en République Démocratique du Congo Rapport d'évaluation*; 2019.
31. Bahrambegi R, Prosnitz D, Wittcoff A, Nichol B, Ratnayake R. *Endline Survey Final Report: International Rescue Committee, Democratic Republic of Congo.* https://www.who.int/malaria/areas/rapid_access_expansion_2015/drc_race_endline_survey1.pdf?ua=1. Published March 2017.
32. USAID Maternal and Child Survival Program. *Mise à échelle de la prise en charge intégrée des cas de maladies de l'enfant au niveau communautaire en République Démocratique du Congo*; 2019.
33. République Démocratique du Congo Ministère de la Santé Publique. *Recueil des Normes d' Organisation et de Fonctionnement des Structures Sanitaires de aa Zone de Sante en Republique Democratique Du Congo*; 2012.
34. University of Antwerp. *Enquete 1-2-3 (2005 & 2012).* <https://www.uantwerpen.be/en/projects/centre-des-grands-lacs-afrique/donnees-nationales-congo/enquete-123-2005-2012/>.
35. Ministère du Plan et Suivi de la Mise en Œuvre de la Révolution de la Modernité. *Document de Stratégie de Croissance et de Réduction de La Pauvreté 2011*; 2011.
36. Englebert P, Mungongo EK. Misguided and Misdiagnosed: The Failure of Decentralization Reforms in the DR Congo. *Afr Stud Rev.* 2016;59(1):5-32. doi:10.1017/asr.2016.5
37. Universal Health Coverage Partnership. *Democratic Republic of the Congo Country Profile.* <https://www.uhpartnership.net/country-profile/democratic-republic-of-the-congo/>.
38. Global Financing Facility, World Bank. *Countries Lead the Way: Delivering on the Global Promise of Better Health and Nutrition: 2019-2020 Annual Report.* https://www.globalfinancingfacility.org/sites/gff_new/GFF-annual-report-2020/index.html. Published Oct 2020.
39. Humana People to People Congo (HPP-Congo). *Strengthening the Community Health Worker (CHW) Systems in Urban and Rural Congo: Annual Report for Integrating Community Health, CHW Award March 2016-March 2017*; March 2016.
40. Humana People to People Congo (HPP-Congo). *Strengthening the Community Health Worker (CHW) Systems in Urban and Rural Congo: Annual Report for Integrating Community Health, CHW Award March 2018-March 2019.* https://pdf.usaid.gov/pdf_docs/PA00TSNG.pdf. Published June 2019.

41. Humana People to People Congo (HPP-Congo). *Description du Projet RECO* (internal document).
42. Humana People to People Congo (HPP-Congo). *ICHHC Presentation: Strengthening the CHW Systems in Urban and Rural Congo*. In: Johannesburg; 2018.
43. Ministère de la Santé Publique. *Cadre d'Investissement pour la Santé Reproductive, Maternelle, du Nouveau-Né, de l'Enfant et de l'Adolescent en vue de l'Atteinte de la Couverture Sanitaire Universelle en République Démocratique du Congo*. <https://www.globalfinancingfacility.org/fr/cadre-d%E2%80%99investissement-pour-la-sant%C3%A9-reproductive-maternelle-du-nouveau-n%C3%A9-de-l%E2%80%99enfant-et-de-l>. Published Nov 2017.
44. Community Health Acceleration Partnership. *Community Health Roadmap: Democratic Republic of Congo*. <https://www.communityhealthroadmap.org/democratic-republic-of-congo>. Published 2019.
45. Global Financing Facility. *Democratic Republic of Congo GFF Country Spotlight*. <https://www.globalfinancingfacility.org/gff-democratic-republic-congo>. Published 2020.
46. Nguyen V-K. An Epidemic of Suspicion — Ebola and Violence in the DRC. *N Engl J Med*. 2019;380(14):1298-1299. doi:10.1056/nejmp1902682
47. Centers for Disease Control. *Overview | Democratic Republic of Congo | Outbreaks | Ebola (Ebola Virus Disease) | CDC*. <https://www.cdc.gov/vhf/ebola/outbreaks/drc/overview.html>. Published Aug 2019.
48. World Health Organization. *Ebola Virus Disease – Democratic Republic of the Congo*. <https://www.who.int/csr/don/03-september-2020-ebola-drc/en/>. Published 2020.
49. Bedford J, Chitnis K, Webber N, et al. Community Engagement in Liberia: Routine Immunization Post-Ebola. *J Health Commun*. 2017;22(sup1):81-90. doi:10.1080/10810730.2016.1253122
50. Ntumba HCK, Bompangue D, Situakibanza H, Tamfum JJM, Ozer P. Ebola response and community engagement: how to build a bridge? *Lancet*. 2019;394(10216):2242. doi:10.1016/S0140-6736(19)32532-2
51. Comité Ministériel de lutte contre la Maladie à Virus Ebola. *Stratégie Intégrée de Réponse au Virus Ebola: Juillet-Décembre 2019; 2019*.
52. USAID. *Democratic Republic of the Congo - Ebola Outbreak Fact Sheet #1, Fiscal Year 2020*. https://www.usaid.gov/sites/default/files/documents/1866/drc_fs01_11-08-2019.pdf. Published Nov 2019.
53. Ministère de la Santé. *Déclaration de S.E. Dr Oly Ilunga Kalenga, Ministre de la Santé de la République du Congo à la Réunion de Haut Niveau sur la 10e épidémie de la Maladie à Virus Ebola (MVE) en RDC*. <https://www.facebook.com/minsanterdc/posts/2440472192700772>. Published July 2019.
54. France 24. *DR Congo unveils new government after months-long delay*. <https://www.france24.com/en/20190826-dr-congo-unveils-new-government-after-months-long-delay>. Published Aug 2019.
55. Strategic Purchasing Africa Resource Center (SPARC). *Live Webinar: From the frontlines of the COVID-19 Response - Lessons learnt from Democratic Republic of Congo*. <https://sparc.africa/event/live-webinar-from-the-frontlines-of-the-covid-19-response-lessons-learnt-from-democratic-republic-of-congo-drc/>. Published July 2020.
56. Ghebreyesus TA. *Kinshasa International Conference on Universal Health Coverage (UHC)*. 2020. [https://www.who.int/director-general/speeches/detail/kinshasa-international-conference-on-universal-health-coverage-\(uhc\)](https://www.who.int/director-general/speeches/detail/kinshasa-international-conference-on-universal-health-coverage-(uhc)). Published Feb 2020.
57. USAID. *USAID Integrated Health Program Fiscal Year 2018 Annual Report*. https://pdf.usaid.gov/pdf_docs/PA00TFDM.pdf. Published Oct 2018.
58. USAID Maternal and Child Survival Program. *National Community Health Information Systems in Four African Countries: Descriptions and Lessons from the Field*. <https://www.mcsprogram.org/resource/national-community-health-information-systems-in-four-african-countries/>. Published July 2019.
59. Government of Democratic Republic of Congo. *Ministerial Order n045/cab/min. gefae/csl/c.adm/amb/2019*. (August 22, 2019).