2022 CLA CASE COMPETITION

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Case Title:

Locally-Led Working Group Moves the Needle on Donor Efforts to Fight COVID in the DRC

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A patient has her temperature taken at a health facility in Bukavu, Sud-Kivu province. Credit: Esther Nsapu for USAID IHP.

Summary:

The Democratic Republic of the Congo (DRC) is a fragile country that is frequently affected by epidemics of diseases like cholera, measles, and Ebola. Despite extensive experience with disease, COVID-19 has been a unique challenge that marked significant drops in service use and quality of care. The emergence of the disease exposed weaknesses in the country's human resource and logistical capacity. Programs funded by an array of international donors seek to mitigate these weaknesses, but with the urgency of COVID-19, it was remarkably inefficient for stakeholders to act in their own silos. Recognizing this need to coordinate efforts, the USAID-funded Integrated Health Program and the DRC's Ministry of Health developed COVID-19 working groups and diverse stakeholder networks to bring the system's bottlenecks and shortcomings to light. As a group, actors ranging from USAID implementing partners to UNICEF, and importantly local community organizations, all shared their experiences across a variety of epidemics and found ways to align their responses to COVID-19. Throughout this coordination, the Ministry of Health was in the driver's seat. During working group discussions, partners raised the frequent confusion that providers experience when attempting to understand the many duplicative or overlapping clinical guidelines shared by the Ministry of Health over time. Pulling from the collective institutional knowledge of the group, USAID IHP led a comprehensive literature review of all historic medical protocols and guidelines and convened sub-committees by technical area to consolidate and streamline them. The Ministry was able to clarify its guidance to health providers, learn from implementation what protocols are realistic, and adapt guidance to these learnings. Throughout this case study, we describe the process of convening a comprehensive working group to address COVID-19, integrating learnings from the Ebola epidemic, responding to failures, consolidating collective learnings, and passing knowledge to community organizations to continue epidemic response efforts into the future.

Which two subcomponents of the Collaborating, Learning & Adapting (CLA) Framework are most reflected in your case? Please reference them in your submission.

- Internal Collaboration
- External Collaboration
- Technical Evidence Base
- Theories of Change
- Scenario Planning
- M&E for Learning
- Pause & Reflect
- Adaptive Management
- Openness
- Relationships & Networks
- Continuous Learning & Improvement
- Knowledge Management
- Institutional Memory
- Decision-Making
- Mission Resources
- CLA in Implementing Mechanisms

1. WHAT: What is the general context in which the case takes place? What organizational or development challenge(s) prompted you to collaborate, learn, and/or adapt?

On March 8, 2020, the Democratic Republic of the Congo (DRC) declared its first COVID-19 case. By May 1st, 2022, the DRC had confirmed 87,425 cases and recorded 1,338 deaths. The DRC is a fragile country affected by several epidemics including cholera, measles, and most recently, the tenth Ebola outbreak in the country. Although this has strengthened the country's capacity to manage epidemics, COVID-19 led to a marked decrease in service use and quality of care as community members feared disease exposure and providers also feared interacting with patients showing symptoms.

USAID's Integrated Health Program (USAID IHP) in the DRC, led by Abt Associates, is working to strengthen the capacity of Congolese institutions and communities to deliver quality integrated health services for malaria; maternal, newborn, and child health; nutrition; reproductive health and family planning; and tuberculosis including 179 health zonesacross nine provinces (Haut Katanga, Haut Lomami, Kasai Central, Kasai Oriental, Lomami, Lualaba, Sankuru, Sud Kivu and Tanganyika).

USAID IHP works with key local stakeholders including the Ministry of Health (MOH), more than ten national health programs, provincial health steering committees, the Provincial Health Districts, and community-level Health Committees, as well as other programs led by implementing partners. The emergence of COVID-19 exposed weaknesses in the health system's human resources, coordination and logistical capacity. This prompted USAID IHP and its many partners to look deeply into lessons learned from the Ebola epidemic and apply them to this new challenge.

2. WHY: Why did you decide to use a CLA approach? Why was CLA considered helpful for addressing your organizational or development challenge(s)?

The Government of the DRC has struggled to provide equitable access to quality essential health care even beyond the COVID-19 context. Declining immunization coverage has led to more frequent outbreaks of measles, cholera, and yellow fever, making the continued provision of essential services for already at-risk populations more important than ever during COVID-19. In the DRC, the array of stakeholders supporting the health system at all levels is vast. From programs funded by donors outside the US government to local nongovernmental organizations working at the community level, there can be dozens of DRC government partners working on a single issue at any given time. Because the pandemic was putting added stress on human resources and the availability of medical supplies, it was not feasible or beneficial to the Congolese people for implementers to continue acting in individual silos. Instead, USAID IHP worked with the Ministry of Health to step back and implement a collaborative approach to these challenges. By developing strong stakeholder networks, we could also bring bottlenecks to light. For example, stakeholders unanimously flagged the confusion of duplicative and misaligned clinical guidelines and the need for a central vision to tie these together for providers. Community organizations lacked tools for managing surveillance information and for disseminating messages on COVID-19 prevention and control to community members. Partners across the health system also noticed that COVID-19 containment measures were putting strains on essential supervision and monitoring activities, which could be strengthened with stronger partnerships.

3. How: Tell us the story of how you used a collaborating, learning and/or adapting approach to address the organizational or development challenge described in Question 2.

When the shock waves of the COVID-19 pandemic reached the DRC, USAID IHP launched a collaborative working group with the Ministry of Health, province-level health system actors, and other local and international partners like Food for Peace, UNICEF, and Breakthrough Action. The working group, led by the MOH and supported by USAID IHP, looked to locally driven approaches and lessons learned from other pandemic responses, especially the Ebola response. The team conducted literature reviews of existing protocols, focusing specifically on documentation of Ebola responses and guidelines. Although Ebola differs from COVID-19, it has epidemiological similarities and comparable prevention measures. Both viruses are transmitted from person to person; Ebola transmission occurs through all secretions, and COVID-19 spreads via respiratory droplets. In fact, the MOH recently worked with partners to halt the country's tenth Ebola epidemic in North Kivu province. Both crises remain at the front and center of national health planning.

In this collaborative effort, the group first identified a need for aligned standards and protocols to ensure the continued delivery of services (preventative and curative) for patients. In the DRC, many separate health management guides and protocols had been drafted at the national level to address epidemics over time. This decentralized knowledge was difficult for service providers to access and understand to implement best practices. USAID IHP facilitated a review and compilation of all existing Ebola management protocols, tools, and international COVID-19 guidelines. The program further supported the organization of working groups by theme and health area —comprised of partners such as the World Health Organization, UNFPA, Tulane University, Engenderhealth, and Sanru—to review the guidelines, and then organized an adaptation workshop to consolidate them into one document. The MOH rapidly adopted these documents at the national level and then worked with USAID IHP to disseminate the guidelines to providers to inform their practice in the context of COVID-19.

At the community level, USAID IHP reinforced the important information contained in the guidelines while working through community organizations. The Program printed awareness-raising posters developed by UNICEF and WHO and disseminated them to community activity units and members of champion communities. USAID IHP also supported the MOH to bring together different technical area experts and community partners to create a communications plan to integrate COVID-19 messaging into other Program community-level prevention and education activities (for example, family planning and maternal health campaigns covered hygiene, infection prevention, and vaccination), disseminate messages through different media, and provide tools for community reporting and decision making at the centres de sante to help inform interventions. For outreach at the community level to overcome the logistical and social barriers that COVID-19 introduced, USAID IHP had to bring community organizations and structures into higher level conversations and working groups. We adopted daily coordination activities with these community groups with the goal of facilitating teamwork and breaking down walls between local and international partners. We also trained community groups to implement integrated disease surveillance, connecting them with the established network of international and country-level health organizations to access and act upon learnings and resources.

4. ORGANIZATIONAL IMPACT: How has collaborating, learning and adapting affected your team and/or organization? If it's too early to tell, what effects do you expect to see in the future?

USAID IHP is already applying the CLA approach presented above as part of its routine activities. For example, we collaborate with other implementing partners to develop and disseminate guides and materials and conduct provider trainings for areas such as surveillance and reporting of maternal deaths. By engaging other partners with complementary scopes, we leverage capacity across different programs to achieve results and avoid duplication.

The Program's initiative to aggregate protocols into purposeful, straightforward guidelines for health providers helped stabilize massive variations in quality of care across facilities. It also taught us that while the act of implementing a best practice is a worthy theoretical goal, reality is rarely straightforward. As a result of our intensive literature review and protocol compilation, providers received unambiguous instructions about when and how to offer care. However, lack of resources at facilities often makes it impossible to follow strict guidelines. For example, a protocol may instruct providers to use a particular thermometer, but the facility has none in stock. Frequent supervisory activities and working group discussions to share such gaps and discrepancies across partner groups enabled us to respond quickly to resource needs or identify alternative protocols. This ability to provide frequent reality checks emerged due to the strong information exchange networks we created at the start of the pandemic.

Overall, the Program—as well as its partner networks—strengthened its already strong relationship with the Ministry of Health and other government agencies. Collaborating with implementing partners is not just a box to check, but a necessary step to ensure interventions are grounded in reality, not duplicative, and rooted in the wealth of learnings that partners bring to the table. This coordination now happens at all levels of the health system, down to the community level, and addresses all aspects of disease control from prevention to surveillance and case reporting. This has helped to ensure the health system's ability to monitor and respond to subsequent pandemics at all levels (from recurrences of COVID-19 to the recent re-emergence of the measles pandemic).

5. DEVELOPMENT IMPACT: How has using a CLA approach contributed to your development outcomes? What evidence can you provide? If it's too early to tell, what effects do you expect to see in the future?

The importance of community partner engagement and resilience in the DRC has been tested during Ebola and now COVID-19. USAID IHP finds that community structures are knowledgeable about and prepared for other pandemics and moments of crisis and serve as our partners at the local level. As a result of our collaborative approach, community groups are trained to use integrated disease surveillance and report weekly to facilities about possible cases. They are also tapped into a network of international and local health organizations that provide continuous learnings and resources to help them implement at the community level. With regular, rapid, and higher quality data reporting from communities, USAID IHP and its partners can more effectively mobilize to respond to challenges.

USAID IHP also observed improved collaboration and disease surveillance across the health system with the creation of the national epidemic control coordination committee and publication of a weekly epidemiological bulletin from the Ministry of Health. It also saw new commitments realized from decentralized entities which engaged in community mobilization and activity financing, with as community activity groups and health committees. With better coordination, each province also made more medical supplies and PPE available in central locations. Finally, the working group developed a task force on medical oxygen once it learned from the group that medical oxygen materials were deficient and routinely unavailable.

Other notable results include improvements to hygiene practices, particularly in hospital settings. Essential equipment and supplies such as water, soap, and gloves are now more widely available than they once were, due to the new straightforward COVID-19 protocols. Hygiene practices also improved at the community level due to USAID IHP's awareness-raising activities on hand washing, social distancing, seeking care when symptoms arise, and minimizing germ spread when coughing.

6. ENABLING CONDITIONS: How have enabling conditions - resources (time/money/staff), organizational culture, or business/work processes - influenced your results? How would you advise others to navigate any challenges you may have faced?

The USAID IHP team's strong relationship with the Ministry of Health has been the cornerstone of our approach and our success. Our leadership and technical experts have adopted a policy of transparency with our government partners, which has given us substantial local partner buy-in that is essential to tackling such a challenging operational climate with vastly different characteristics across the provinces and health zones. We are upfront about what we can and cannot do, which is an attribute that the Ministry and other directorates within the government appreciate and strengthen with honesty in turn. Programmatically, we tapped champions within the Ministry of Health to advocate for change and increased collaboration with USAID IHP as well as other partners. However, the Ministry's willingness to engage in learning activities is not an outcome of interventions but a remarkable feature of the Ministry itself that USAID has helped foster over many years of partnership. USAID IHP has found great success in supporting and conducting advocacy from behind while allowing the Ministry to lead; coordination and support can build on strong governmental capacity to ensure activities are implemented efficiently.

The Program also benefitted from a significant footprint of epidemic response in the country. Guidance and training materials were abundant from previous crises, and we were in the fortunate position of not having to reinvent the wheel. However, an abundance of information can pose its own unique challenge when information is contradictory or requires massive labor power to compile. When possible, a single first step is essential: review what exists, consolidate, and build upon it.
It is a well-known and tested adage that governments are our greatest partners, but it is essential to meet this principal with actions that demonstrate a Program's transparency with its partners. Sharing data for decision making in real time, engaging host country partners in problem solving directly, and ensuring the engagement of community actors and leaders from day one can create an environment wherein partners are willing to take advantage of new collaborative opportunities.