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Integrated Health Project in Democratic Republic of Congo:

A Case Study on Citizen Engagement and its Influence on Health Program Outcomes

June 29, 2016

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Contents

Abbreviations and Acronyms

BCC	Behavior Change Communications
CHW	Community Health Worker (*relai communautaire*)
CODESA	Community Health Committee (*comite de developpement sanitaire)*
CPA	Complementary Package of Services
CSS	Client Satisfaction Survey
CUG	Closed User Group
DRC	Democratic Republic of Congo
ETL	Education Through Listening
FOSACOF	Fully Functioning Service Delivery Point (
FP	Family Planning
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
i-CCM	Integrated Community Case Management
IHP	Integrated Health Project
IR	Intermediate Result
KAP	Knowledge, Attitudes and Practices
LDP	Leadership Development Program
LG	Local Government
LMG	Leadership, Management and Governance
LMS	Leadership + Management + Sustainability
MNCH	Maternal and Child Health and Nutrition
MOH	Ministry of Health (*Ministere de la Sante Publique*)
MPA	Minimum Package of Activities
MSH	Management Sciences for Health
NGO	Nongovernmental Organization
PHC	Primary Health Care
RH	Reproductive Health
RBF	Results Based Financing
TB	Tuberculosis
UN	United Nations
USAID	United States Agency for International Development

Executive Summary

This case study explores how health interventions can be enhanced through the active engagement of community members. It documents the experience of the Democratic Republic of Congo (DRC) Integrated Health Project (IHP), which was implemented under a cooperative agreement between Management Sciences for Health (MSH) and partners with US$139 million in funding from the United States Agency for International Development (USAID). In analyzing IHP's citizen engagement interventions, the case study seeks to document how these interventions may have influenced overall Project implementation and outcomes.

IHP financed interventions to strengthen access, availability, and quality of health services in almost 80 health zones in DRC between 2010 and 2015, while concurrently engaging citizens to improve their health practices and behaviors through a variety of groups. The theory of change embodied in its conceptual framework rests on a belief that effective, enhanced supply and quality of health services requires motivating citizens both to use health services and to improve their own health practices, which, in combination, can lead to improved health outcomes.

The literature on the role of citizen engagement in improving health outcomes suggests it is not possible to attribute IHP Project outcomes definitively to individual, or even a collection of, citizen engagement interventions. Moreover, lower fees at health centers due to programs introduced by IHP, such as results-based financing, have likely been a critically important factor in encouraging citizens to use health services. However, according to key informants, a number of IHP measures to support citizen engagement were helpful in motivating improved health behaviors and use of health services. Most significant among these were: (1) support to community health development committees, known as *CODESAs* (*Comités de developpement sanitaire),* which created a two-way communication and consultation network between citizens and health service providers; and (2) the development of community action organizations called *Champion Communities,* which spearheaded community health action plans and campaigns while developing a sustainable framework (NGO status) to carry forward their work. The Project also piloted *a client satisfaction survey* to provide structured feedback, which has the potential to strengthen management of health centers. Project efforts to strengthen citizen involvement in health policy and planning at the provincial level were not successful due to the overall weak governance that characterizes the sector.

Two factors in particular contributed to positive results in implementing citizen engagement approaches. The first was a Project design that made "people-centered" approaches integral to many of the Project's components, with an emphasis on dialogue and personal empowerment to promote internally motivated behavior changes. The second was the inclusion of measures to strengthen both the *supply* (quantity and quality) of health services and the *demand* (citizen interface groups and accountability measures) for health services. Results-based financing further incentivized both health service staff and citizen groups to improve services.

Major challenges to achieving the sustainability of citizen engagement initiatives and, more generally, Project outcomes, relate to the weak capacity of citizen groups due to poverty and low human development levels; efforts are also hampered by the weak governance and limited financing that characterize the health sector in DRC. This results in a continuing need for both citizens and donors to finance the vast majority of health expenditures.

In this context, donor financing of citizen engagement in the health sector is likely to be most effective when it focuses on the following:

- Including citizen engagement measures that foster both *consultation and participation* to stimulate positive health practices, as well as *(social) accountability* to improve governance;
- Financing interventions to *strengthen concurrently both citizen groups and health service infrastructure and capacity,* including the use of *results-based financing* to incentivize both groups;
- Building into Project design instruments for *monitoring and evaluation* of citizen engagement measures; and
- Continuing *dialogue with government* to strengthen the governance framework for provision of health services.

I. Introduction

This case study explores how health interventions can be enhanced through the active engagement of community members. It documents the experience of the Democratic Republic of Congo (DRC) Integrated Health Project (IHP), which was implemented under a cooperative agreement between Management Sciences for Health (MSH) and partners from 2010 to 2015 with US$139 million in funding from the United States Agency for International Development (USAID). In analyzing these citizen engagement interventions, the case study seeks to determine how they may have influenced overall Project implementation and outcomes. Appendix A provides the scope of work for the case study prepared by MSH.

This introductory section sets out the rationale for citizen engagement, a brief overview of the program, the objective of the case study, and the methodology for, and limitations of, the case study research. It is followed by the three sections described below:

- ***Section II*** provides a deeper understanding of the Project context, content, and relationship of the citizen engagement instruments to Project design and implementation, including the Project's theory of change.

- ***Section III*** presents the implementation results and outcomes for the citizen engagement interventions vis-à-vis the overall Project, including an analysis of positive factors and constraints that affected outcomes.

- ***Section IV*** sets out conclusions reached on the basis of the analysis and recommendations for future design of health programs and associated citizen engagement instruments.

Rationale for Citizen Engagement

Citizen engagement can be defined as "the two-way interaction between citizens and governments or the private sector . . . that gives citizens a stake in decision-making with the objective of improving the intermediate and final development outcomes of the intervention."[1] Inclusion of citizen engagement in development programs, including those supporting the health sector, is based on the premise that giving citizens a voice will help ensure that programs are tailored to their needs, will build a greater sense of ownership by the community, and will make service delivery more accountable — all of which will contribute to more effective service delivery. While earlier-generation health projects emphasized training or information to induce behavior change and to thereby improve health outcomes, the trend is now toward a greater focus on empowering citizens to take responsibility for their health decisions and practices, to collaborate with health providers, and to hold providers accountable for increased access to and quality of health services. Research evidence confirms the potentially positive — though variable — impact of citizen engagement on health outcomes.[2] Successful interventions usually focus on raising community awareness of targeted health issues and encouraging dialogue and community ownership.[3]

[1] World Bank, Strategic Framework for Mainstreaming Citizen Engagement in World Bank Operations. World Bank, 2014. p. 8. https://openknowledge.worldbank.org/handle/10986/21113.
[2] Judith Edstrom, Engaging Citizens in Health Service Delivery: A Review of the Literature, MSH, 2015, p. 9.
[3] C Marsten, A. Renado, C.R. McGowan, A Portela. Effects of Community Participation on Improving Uptake of

The broader literature on citizen engagement normally places citizen interventions along a continuum of increasing citizen decision-making authority. Transmission of information to citizens is at one end of the spectrum, while full empowerment of citizens to make decisions is on the other. Analyzing citizen engagement in health results can be challenging because health service providers — including volunteers at the community level — have generally sought to "engage" citizens as part of health promotion. However "citizen engagement," as defined above, conveys a somewhat more structured — often collective — exchange aimed at giving citizens a greater stake in decision-making and outcomes. As such, health promotion is not considered to be citizen engagement. Section 2 sets out a framework for classifying the citizen engagement instruments of IHP, recognizing that there may not be a clear distinction between citizen engagement and good health promotion that engages citizens.

Program Overview

The overall objective of the $139.8 million DRC Integrated Health Project is to "improve the enabling environment for, and increase the availability and use of, high-impact health services, products and practices for family planning (FP), maternal, newborn and child health (MNCH), nutrition, malaria, and tuberculosis (TB)." It includes four areas of intervention: (1) improvements in the physical and human health infrastructure to effectively expand the *quantity* of health services; (2) investments to strengthen the *quality* of health services through enhanced human capacity, as well as standards and practices; (3) investments in outreach, mobilization, and campaigns to *engage citizens* in improving health behaviors; and (4) support to health sector management in targeted provinces to improve planning, management, and overall *governance* of health services.

To carry out the citizen engagement instruments, the Project created or strengthened multiple groups through which outreach was to be extended, such as health development committees, community groups called Champion Communities, as well as Closed User Groups (CUGs) and other groupings. Most of these are citizen/community interface groups; a few are intended to play a governance role related to health facility management.

The Project documents assume that "an essential condition for measurable impact [in improved health outcomes] is empowerment: greater understanding of individual roles and responsibilities throughout the health system leads to changes in attitudes, and motivation to make incremental changes that can ignite a chain reaction across the sector. And this shift results in improved health services and other health systems, for a greater health impact on patients."[4]

The theory of change[5] embodied in this conceptual framework is that, to be effective, achieving enhanced supply and quality of health services requires motivating citizens to become empowered to use health services and to improve their own health practices and behaviors, both of which can lead to improved health outcomes. Implicit in this theory of change is that the attitudes and motivation of health service providers also change — ie, that they respond to public demand by providing more of the services desired.

Skilled Care for Maternal and Newborn Health: A Systematic Review. 2013, PLoS One. 8(2): e55012 doi:10.1371/journal.pone.0055012. p. 7.

[4] Management Sciences for Health (MSH), Integrated Health Project (IHP) for the Democratic Republic of Congo RFA-OAA-10-000006: Technical Application, 2010, p. 3.

[5] Analysis and associated schematic for this theory of change appear on page 7.

Objective of the Case Study

The purpose of the case study is two-fold. First, it seeks to analyze the validity of this theory of change, but it also aims to gauge the effectiveness of the Project's interventions in eliciting this enhanced citizen engagement and, beyond that, the contribution that greater citizen involvement may have made to achieving the Project's objectives within its wide range of interventions. It examines how and why citizen engagement approaches gained traction, based on both observed or documented outcomes and stakeholder perceptions (both public servants and citizens). The case represents a critical test of the Project's theory of change regarding how — or even, if — citizen engagement enhances health service delivery.

Case Study Methodology

The case study uses standard theoretical design and methodology for case study research, as described in *Case Study Research: Design and Methods* (Robert Yin, 2014, 5th edition), to explore how citizen engagement has influenced the selected health interventions. This approach is valid for increasing the evidence base on how citizen engagement influences health program implementation and outcomes — albeit with some limitations — as discussed below. The unit of analysis, which establishes the boundaries of the case, is the subset of the Project that included citizen engagement initiatives as they related to the broader Project.

The research methodology is that of a freestanding single-case analysis in that it is not part of a broader research effort incorporating surveys and other quantitative and qualitative data collection. Because the research was conducted largely after the completion of the 2010-2015 Project activities,[6] it utilized data collected during Project implementation. New research relied primarily on qualitative techniques, such as key informant interviews and small group discussions, to explore and verify the role community members and beneficiaries played in the health intervention.

The analysis built on the initial theoretical proposition about the effectiveness of citizen engagement in improving health services. Analytic techniques relied primarily on logic models and

Box 1: IHP Case Study: Research Phases

Reviewed all available Project documentation — This included: the technical proposal; annual work plans; performance-monitoring plans; quarterly and annual reports; selected trip reports; mid-term and other evaluations; miscellaneous Project documents; and analyses of the DRC health sector and country situation more generally.

Conducted focused telephone interviews — Key informants, including the MSH Country Director for DRC, IHP Chief of Party, and other MSH staff, were interviewed to improve understanding of the Project, expectations for the case study, and plan the visit trip.

Developed an interview "protocol" — Determined topics to be covered and questions for guided discussion, including a checklist of questions to citizen groups and staff during health center visits.

Visited the country — Visit of about two weeks to DRC, of which one week was spent in Kasai Oriental province where they observe health facilities or continuing interventions introduced under the Project, reviewed archival material available locally, and conducted targeted interviews with key informants and beneficiaries, including Ministry of Health (MoH) officials at both national and local levels, and had small-group discussions with groups of community leaders, citizen activists, and beneficiaries in three health zones in Kasai Oriental province.

Drafted the case study — This phase included circling back to DRC-IHP staff to clarify field observations. Data compiled was corroborated through multiple sources of evidence. The final product incorporated feedback from MSH [and USAID].

[6] USAID granted a one-year bridge project (IHPplus) under the Evidence to Action (E2A) project to continue the most critical activities, pending development and award of a follow-up project.

explanation building. Likewise, the analysis considered factors that may have enabled or impeded these outcomes. Among other things, these factors relate to the political enabling environment, commitment and capacity of government and service providers, and appropriateness and effectiveness of approaches used to engage citizens.

The methodological phases of the research are shown in Box 1, "IHP Case Study: Research Phases." Appendix B provides the research interview protocol describing the lines of inquiry and checklist for health center interviews. Appendix C provides a list of key sources of information (documents consulted and key informants interviewed).

Case Study Limitations

A primary limitation to the potential robustness of this case study research is that it was not designed ex-ante as a research effort to test particular hypotheses; thus the data needed to assess intervention effects are generally lacking. The period allocated for the country visit was limited to 12 days in-country, thereby permitting observation of a relatively small number of sites, particularly in view of the difficult transport conditions in DRC. In addition, a final evaluation of the Project is being undertaken concurrently with preparation of this case study. Data on health outcomes being gathered within that evaluation, which might potentially be triangulated with the locations of successful citizen interventions, is not yet available. However, it is unlikely that even this evaluation would have collected data that would permit correlation with citizen engagement interventions if not designed specifically to probe for it. Definitive attribution of outcomes to citizen engagement instruments is therefore not possible.

Moreover, more global reviews of evidence of the impact of citizen engagement instruments on health service delivery and health outcomes are consistently reluctant to draw conclusions regarding the impact of any single citizen engagement instrument — or even a group of instruments. And because programs generally employ a variety of citizen engagement mechanisms concurrently, outcomes are generally not attributable to any single citizen engagement instrument.[7]

II. Project Description and Theory of Change

Country Context [8]

The enabling environment for implementing health programs like IHP is particularly challenging in the Democratic Republic of Congo. With a Human Development Index ranking of 187th out of 187 countries (UN 2013), health indicators in DRC are among the worst in the world. Crude mortality rates are estimated to be 40 percent higher than the average for Africa, with a maternal mortality ratio estimated at 846 per 100,000 live births, and an under-five mortality rate of 104 (per 1000). The prevalence of malnutrition among pregnant women and children under age five is also among the highest in Africa, and is directly linked to poverty and inadequate hygiene and sanitation. Nearly

[7] G. Mansuri, V. Rao. **Localizing Development: Does Participation Work?** World Bank, 2013, p. 200.

[8] Unless stated otherwise, data in this section is from: World Bank, Health System Strengthening for Better Maternal and Child Health Results: Project Appraisal Document on a Proposed Credit and Grant to the Democratic Republic of Congo (total US $226.5 million equivalent), November 2014. The document states that all data in the Project Appraisal Document rely on the official DHS-2013-2014 data released in October 2014.

97 percent of the population lives in malaria-endemic areas. Disease prevalence, including for HIV/AIDS and tuberculosis, is also among the highest globally. Some improvements have been registered, notably in the uptake of preventive measures: 70 percent of the population possess an insecticide-treated bed-net, 85 percent of pregnant women receive some antenatal care by trained professionals, and two-thirds of births take place in a health facility.

Weak governance and institutional capacity, as well as limited health funding, contribute to DRC's poor health indicators. Public resources devoted to health are among the lowest in the world, with the DRC government spending approximately US$1 per capita per year for health. This represents an increase from 2003 (US$0.40), but a decrease from 2007 (US$1.50). Until recently, government health spending averaged about 4 percent of the budget; in 2015 this is reported to have increased to 8.6 percent of the budget.[9] However, the majority of the health budget is used to finance staff salaries in Kinshasa and a few provinces, and actual financial disbursements tend to be significantly lower than budgeted amounts. With these limitations in public funding, nearly 70 percent of the health workforce does not receive a salary, requiring them to charge fees at the facility level. The majority of health expenses are financed through out-of-pocket spending by households (37 percent) and financial and technical partners (47 percent). It is estimated that two-thirds of patients do not rely on the formal health care system due to unavailability of services and drugs or inability to pay.

Citizen Engagement within the Integrated Health Project

Integrated Health Project Vision and Results Framework

The IHP was conceived as a five-year project (2010-2015) to pursue the following vision:

> "People in Project health zones will participate more fully in determining their health outcomes by virtue of greater access to higher quality comprehensive care; service delivery systems that are accountably and effectively managed in their interests; and family-centered communication about healthy behaviors that people understand and can act on in their daily lives." [10]

Project financing of US $139.2 million supported equipment (4%), pharmaceuticals (26%), training (8%), cash transfers (for RBF, subgrants and other) (32%), and Project staff support (30%) to almost 80 health zones in four provinces of DRC to achieve service delivery and other health system results. (Figures represent percentages of Project expenditures net of overheads.)

Figure 1 presents the Project results framework, including four intermediate results (IR) and associated strategies or activities:

[9] USAID, Special Notice # OAA-660-20150819, Prospective Activity named "Integrated health Program in DRC (IHP-DRC), Attachment 1, 2015, p. 19.
[10] MSH, op. cit., p. v.

Figure 1: Integrated Health Project Results Framework

USAID DRC Health Assistance Objective: Improve the basic health conditions of the Congolese people			
IHP Project Objective: Improve the enabling environment for, and increase the availability and use of, high-impact health services, products, and practices for FP, MNCH, nutrition, malaria, and TB			
Intermediate Result 1 Access to and availability of MPA-plus and CPA-plus services and products in target health zones increased	***Intermediate Result 2*** Quality of key family health care services (MPA/CPA-plus) in target health zones increased	***Intermediate Result 3*** Knowledge, attitudes, and practices to support health-seeking behaviors increased in target health zones	***Intermediate Result 4*** Health sector leadership and governance in target provinces improved
Strategies/Activities by Sub-Intermediate Result (IR)			
1.1: Increased facility-based health care services/products • Provide materials • Provide essential medicines, commodities, and materials 1.2: Increased community-based health care services/products • i-CCM at community treatment sites • CODESA – collaborative strategy at community level 1.3: Effectively engaged provincial mgt. • Leadership Development Program	2.1: Clinical and managerial capacity of health care providers • Training, supportive supervision 2.2: Minimum quality standards • Fully Functioning Service Delivery Point (FOSACOF) • Results-based financing (RBF) 2.3: PHC referral system for prevention, care, and treatment	3.1: Health sector – community outreach linkages • CODESA • Youth outreach groups 3.2: Health advocacy/community mobilization organizations • Education through Listening (ETL) • CODESA 3.3: Behavior change campaigns • BCC messaging	4.1: Health sector policy alignment 4.2: Evidence-based strategic planning and decision-making 4.3: Community involvement in health policy/service delivery

While IR 3 activities appear to be the ones most directly related to community engagement, measures to engage citizens were incorporated into activities of all four IRs. Moreover, as revealed in the results framework above, some of the same community organizations, such as community health development committees (*Comité de développement sanitaire*—CODESA), supported more than one IR.

Citizen Engagement Framework

IHP's numerous measures to engage citizens fall along a spectrum of citizen involvement in decision-making, as shown in Figure 2, "Citizen Involvement in Decision-Making in IHP." It defines a continuum of citizen engagement approaches and shows where the instruments used in IHP are situated along it.

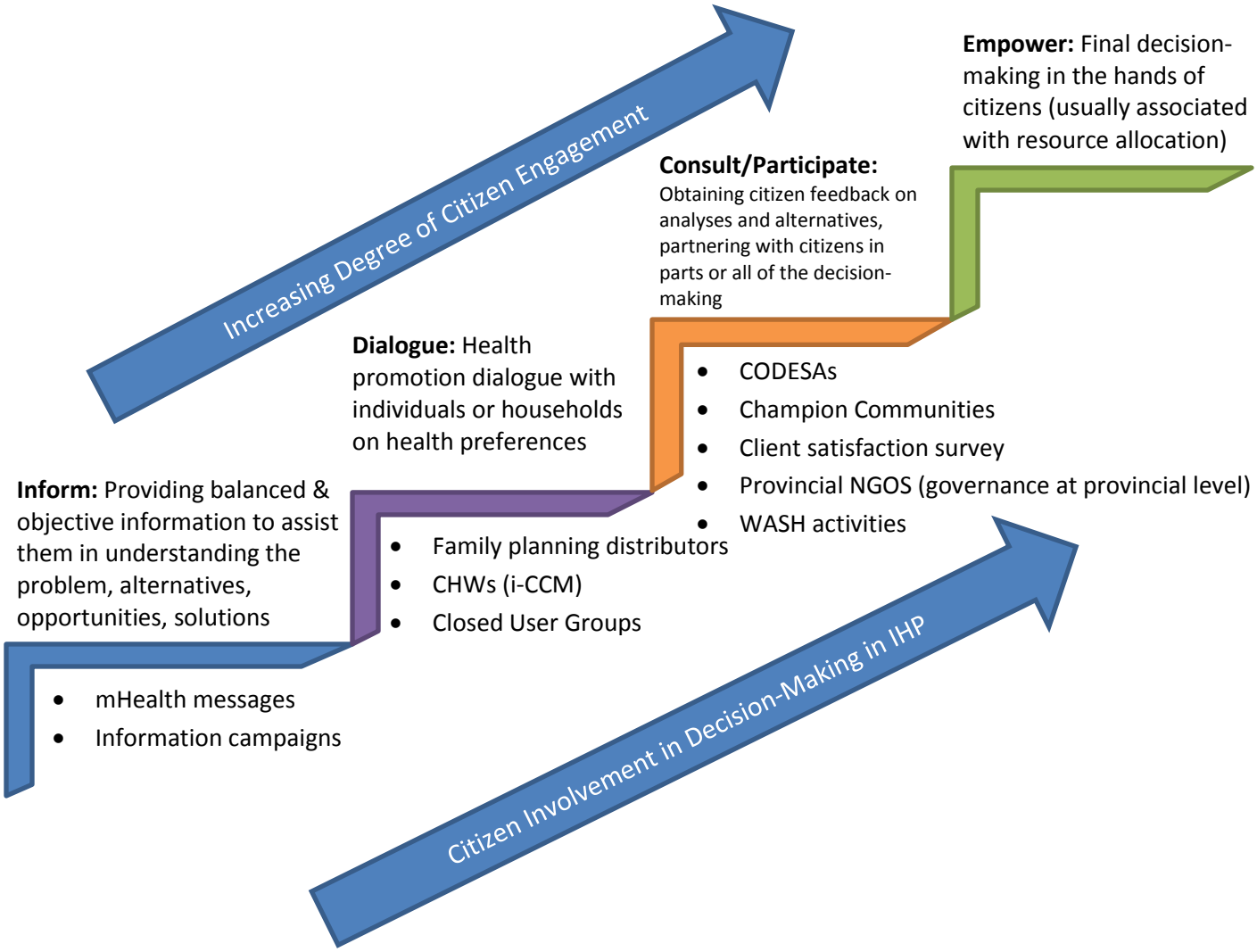


Figure 2: Citizen Involvement in Decision-Making in IHP

Source: adapted from "IAP2 Spectrum of Public Participation," International Association for Public Participation.

While Information is not considered to constitute citizen engagement, as such, it is included in the schematic because availability and transparency of information is an important prerequisite to citizen engagement. For example, information and media campaigns — as well as informative messages delivered via SMS or mobile phones — are not considered citizen engagement, as these represent primarily one-way information flows. Located on the other end of the spectrum, empowerment refers in most sectors to legal or quasi-legal power for community ownership or authority to make decisions on resource allocation. In health, it is often used in more conceptual

terms to convey the impression that citizens become personally or socially "empowered"[11] to take charge of their own health outcomes. IHP has generally employed the term in this sense. However, since it manifests more as a resulting behavior than as a specific instrument, none of the citizen engagement instruments in IHP is placed directly in that category.

A number of IHP community-based interventions, such as the integrated community case management approach (i-CCM) that revitalized the cadre of community health workers (CHWs-*relais communitaires*), played a major role in engaging and linking communities with the formal health system. Similarly, the family-planning distributors engage in dialogue with target audiences. These very important health promotion activities, generally conducted at the level of the individual or household, fall more within — or closer to — the category of information than consultation within the lexicon of citizen engagement.[12] As such, they are not generally considered a form of citizen engagement.

IHP Citizen Engagement Instruments

This case study focuses on the Project interventions that constituted the primary *structured* citizen engagement groups or instruments of the Project, which are depicted in Figure 2 as forms of consultation and participation.[13]

They include:

- ***Supporting the CODESAs,*** the existing committees associated with each health center. Made up of volunteer CHWs, CODESAs have been mandated since 2003 to mobilize community members to use the services of health centers, and to "stimulate them to play a more active role in health service delivery by helping them to identify health challenges, develop, a shared community vision, set priorities and develop action plans to mobilize community members and resources, and to strengthen two-way community-health center referral networks."[14]

- ***Creating or strengthening Champion Communities,*** as the health advocacy and community mobilization organizations are known. The intent is to galvanize and involve communities in environmental and family health campaigns and activities, and to provide a participatory framework to create a platform for communities to identify and respond to local health challenges. The ultimate aim is for them to become self-financing NGOs.

[11] The Merriam Webster dictionary defines this interpretation of empowerment as "self-actualization," versus the more restricted definition as gaining power to control resources.

[12] "Consultation, as distinct from dialogue, is a structured exchange in which the convener commits to 'active listening' and to carefully consider the comments, ideas, and recommendations received. Good practice consultations provide feedback on what was heard, and what was or was not incorporated and why to ensure that consultations contribute to improved policies and programs." World Bank, op. cit. p 65: Annex 1: "Overview of Citizen Engagement Mechanisms, Definitions and Uses." For definitions of other citizen engagement terms, see: https://openknowledge.worldbank.org/handle/10986/21113.

[13] The Project's Water/Sanitation/Hygiene activities, undertaken in nine zones, used citizen consultation approaches by involving religious and community leaders, and may have relied on CODESAs or Champion Communities where the latter existed. WASH activities are therefore included in Figure 2. However this initiative was not a distinct, structured citizen engagement instrument and is therefore not assessed in this case study.

[14] MSH, op. cit., p. 10.

- ***Creating Community User Groups*** (CUGs) made up of citizens selected by their communities. CUGs organize information around health topics and serve as a reference relay between health services and citizens needing assistance or a response to health queries.

- ***Introducing a client satisfaction survey*** as part of the assessment package for the results-based financing (RBF) introduced in late 2013 in targeted health zones.

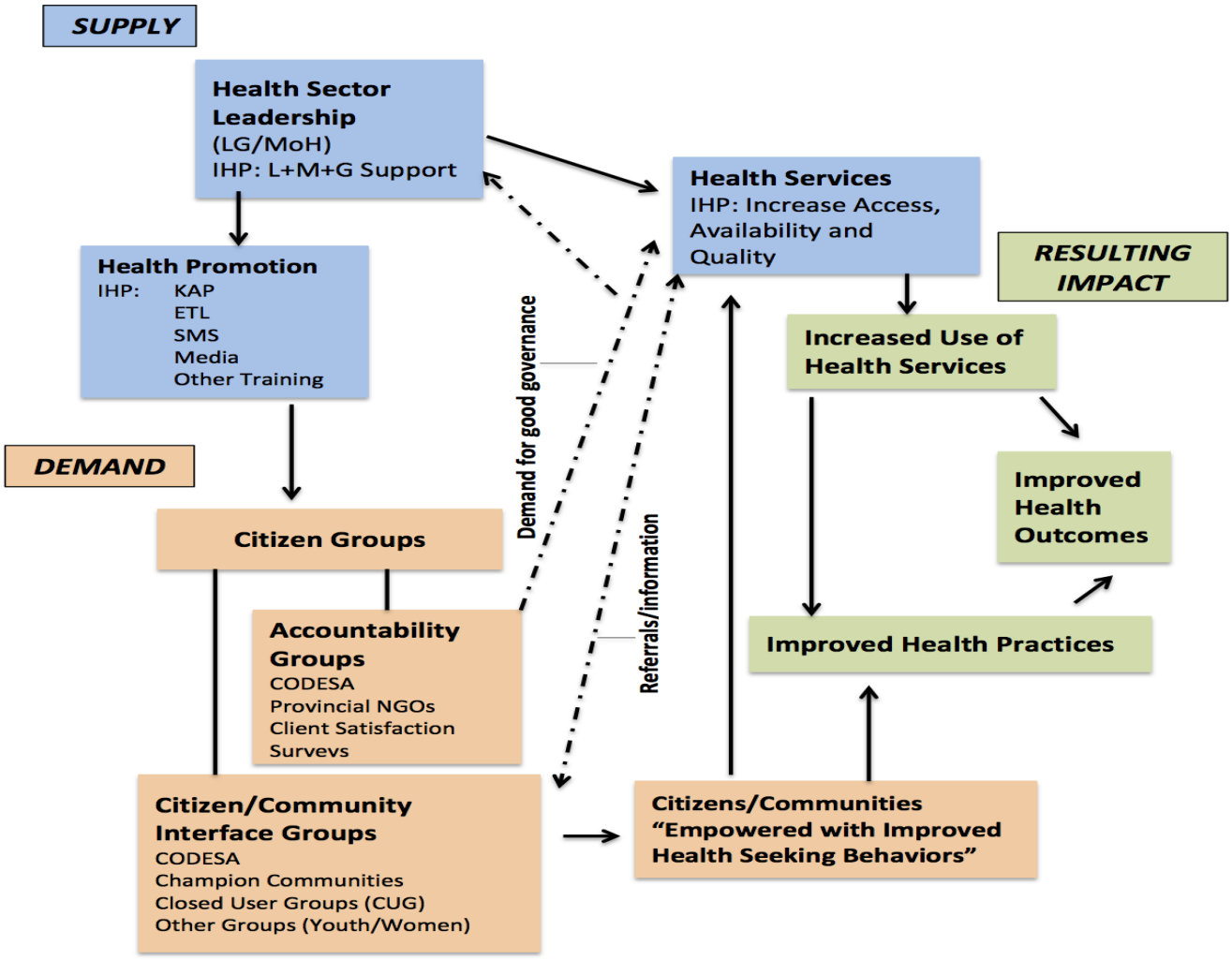
- ***Institutionalizing community involvement in health policy and service delivery***, including at the provincial planning and budgeting level, through support to CODESAs and provincial-level NGOs.

The intended, actual, and evolving degree of citizen engagement of each of these instruments is discussed in Section III of the report covering results and outcomes, which also provides a fuller discussion of how these were applied.

IHP Theory of Change

The relationship of the citizen engagement interventions to the other components of the Project can best be understood by examining the Project's theory of change, as depicted in Figure 3. It shows the relationships between supply of and demand for health services, and the assumed resulting effect on health outcomes.

Figure 3: DRC Integrated Health Project Theory of Change



Supply

The supply side of the equation (shown in blue) represents the investments under IHP. It is composed of health sector (government) leadership, health services, and health promotion activities provided by the Project or health service personnel.

IHP provided support to:

- ***health sector leadership*** (IR 4) — This was done through provision of technical support and the Leadership Development Program (LDP) for health managers. The LDP is a structured, team-based program to enable health care workers and managers to develop leading, managing, and governing practices to address their most critical challenges in the workplace.
- ***health services*** (IR 1 and IR 2)— This was done through infrastructure, equipment, and commodities support, as well as technical support, training, and RBF to selected health zones and health centers. It used a Fully Functional Service Delivery Point Model, to strengthen the availability and quality of health services in 80 (later revised to 78) health zones in four provinces of DRC.
- ***health promotion*** — This was done by supporting the activities needed to reach out to citizens (IR 3), with an emphasis on behavior change modification and community ownership to increase "knowledge, attitudes, and practices that support health-seeking behaviors."

Demand

On the demand side (shown in orange), the Project supported or helped create two kinds of citizen groups to achieve different goals:

1. The first comprised citizen or community interface groups whose primary purpose was to stimulate — through dialogue, listening, and knowledge exchange — the "empowerment" of citizens to take an enhanced role in their health outcomes by creating stronger health-seeking behaviors. Its goal was ***to lead citizens to increase their use of health services and to adopt improved health practices***. These groups also have direct relations and interactions with the health services for referral/information purposes, which are aimed at improving these services and making them more responsive.
2. The second kind of group — sometimes embodied in the same organization — is one whose purpose was ***to support good governance***, holding services "to account" through oversight of budget or service delivery or direct feedback on service delivery —for example, through a client satisfaction survey. These groups provided feedback to either health centers or health zone management to strengthen governance practices. This "social accountability"[15] role may have been implicit in the Project's conceptual framework, but was considerably less fleshed out than that for community interface groups.

[15] Social accountability is defined as "the broad range of actions and mechanisms beyond voting that citizens can use to hold the state to account, as well as actions by government, civil society, media and other societal actors that promote or facilitate these efforts" (McNeil and Malena 2010).

Impact

The resulting impact (shown in green) of increased use of health services and improved family health practices, which also create a virtuous circle between each other, is improved health outcomes.

The following section examines the extent to which this theory of change played out as Project implementation progressed.

III Citizen Engagement: Implementation Results and Outcomes

This section examines the effectiveness of selected citizen engagement instruments within IHP in achieving the objectives set for each of them, as well as their influence on the attainment of the overall Project objectives depicted in its theory of change. It seeks to ascertain both the extent to which they reflected citizen engagement — versus acting as an extension of the formal health services — and the degree of citizen decision-making or empowerment in each, as presented in Figure 2. It considers both constraints and positive factors that affected their achieving their intended objectives, as well as the potential sustainability of these interventions.

The analysis focuses on four citizen engagement instruments that the researcher was able to observe firsthand,[16] namely the CODESAs (9), Champion Communities (1), client satisfaction survey (covering 17 health centers), and the provincial governance component (discussions with various informants at provincial level in Kasai Oriental). The fifth citizen engagement instrument described below, the CUGs was not observed, as it was discontinued in January 2015 for financial reasons; it is briefly cited in the discussion below as it relates to the other components, relying on two evaluations that have been undertaken on the CUGs.

Implementation of Citizen Engagement Instruments

CODESAs

The community health development committees (*Comités de développement sanitaire* — CODESAs) are in many respects the "workhorse" of the citizen engagement initiatives of IHP — as exemplified by their inclusion in several of the Project's sub-IRs and activities. These committees, whose existence predated IHP, are created at each sub-zone (*aire sanitaire*) of the health zone, and are linked directly to the sub-zone's health center. Their members consist of volunteer community health workers (CHWs) working in the sub-zone. There are normally about 20 people in each CODESA; they are elected or designated by fellow community members. At Project inception, many CODESAs were relatively inactive, as were a considerable number of the CHWs who were CODESA members.

IHP's objectives in support of CODESAs included the following:

[16] Numbers in parentheses represent the numbers of groups interviewed or sites covered.

- Strengthening the involvement of CODESAs (including revitalization of nonfunctioning CODESAs) in health system management;
- Supporting their role in two-way community-facility referral networks; and
- Strengthening their role in health advocacy and community mobilization.

The Project's performance management plan included two indicators related to CODESAs, against which significant progress was made during Project implementation, as shown in Table 1, "IHP Performance Indicators for CODESA":

Table 1: IHP Performance Indicators for CODESA

Indicator	**# and % of total September 30, 2011 (end of Year 1)**	**# and % of total June 30, 2015**
Communities supported by IHP that have CODESAs actively involved in management of priority health services	859 (61%)	1398 (100%)
CODESAs supported by IHP that have a "communications action plan"	0 (0%)	1192 (85%)

During Project implementation, the second indicator appears to have been converted to more comprehensive "action plans" embracing what the IHP Quarterly Report (April-June 2015) called "self-designed solutions to community health problems." However, the examples provided suggest that these plans remained primarily focused on conveying health messages and engaging group discussions of health issues. It is also difficult within these process indicators — as is the case in general with indicators that attempt to measure citizen engagement interventions — to capture the degree of dynamism of different CODESAs.

Indeed, Project quarterly reports noted difficulties in motivating individuals to become CODESA members due to the absence of financial incentives and their weak capacity. They are obliged to fulfill their roles as CHWs in transmitting health messages and serving as a referral contact between health centers and communities while still serving the "committee" functions (particularly meetings) of being CODESA members. To deal with these challenges, IHP provided modest fixed subsidies to CODESAs for their monthly meetings, as well as training in a number of areas. The Project also encouraged implementation of income-generating activities to provide financial support for their transport and other community activities in which they engage, such as undertaking small improvements (e.g., fence enclosures) for the health centers. These admittedly do not fully offset the lack of motivation among the volunteers who serve as CHWs and CODESA members.

With regard to the degree of citizen engagement in the role of CODESAs, their "participation in health system management" was included among the areas of IHP's focus. However, the emphasis — at least initially — was on using the CODESAs as extensions of the health system to mobilize community campaigns and resources and to spread health messages. This would include organizing community distributors of family planning commodities, suggesting that their role leaned toward the "information" end of the citizen engagement spectrum.

However, based on group discussions with almost 50 CODESA members representing 9 CODESAs, as well as with the staff of each of the five health centers visited, this role appears to be shifting to one that is more genuinely consultative and participatory in some instances. As described more fully in Appendix D, "Matrix of Discussions with CODESA and Health Center Staff," these discussions probed the following: their motivation for becoming CHWs, which is a prerequisite for becoming a member of a CODESA; the role they see for themselves as CHWs and as CODESA members; their activities; their ability to perceive community health issues and changes in health practices over time; and their potential for serving as an instrument for social accountability. While these volunteers may not be able to fully differentiate some of their functions as CHWs from those as CODESA members, the strong motivation of many of them to move beyond information provision was apparent.

Specifically, CODESA members interviewed consistently see themselves as representatives of the community rather than as spokespersons for the health system. Further, they see their role as a bridge between the two, carrying information in both directions. One member stated that people have a right to give feedback to the health center, not just to receive information. Others pointed to the communal fields that some CODESAs have for crops or small livestock to raise funds as a collective enterprise. (However, one member expressed uncertainty as to how the funds deposited into their savings account were to be used.) Other examples of their perceived role include: helping to review the health center's performance indicators; negotiating a reduction in health center user fees; organizing deferred payment — or even dropping fees entirely — for health services on behalf of those unable to pay; or bringing to the attention of the health center a patient unwilling or unable to come to the health center for recommended services (antenatal care, vaccinations). Although some of these activities may characterize those of a committed CHW, without the need for a collective organization such as CODESA, it was reported that the more dynamic CODESA members appear to have had a galvanizing effect on the less motivated members, thereby validating the beneficial effect of the committee.

However, CODESA members were not uniformly aware of some of the instruments under IHP that related to them. Specifically, most seemed to be unaware of the CODESA action plan, which is one of the IHP indicators. And none of the three CODESAs whose health center employed a citizen satisfaction survey under the RBF had heard of it.

Nonetheless, RBF — along with other innovative approaches adopted by IHP to partner with other donors to bring drugs and other commodities or equipment to the health centers — appears to have created a motivating effect on both health center staff and CODESAs.[17] Most notably, through RBF and programs to bring drugs and/or a cash infusion to the health center, user fees have been lowered significantly, which, according to CODESA members, has created the single most important stimulant to citizens to visit health centers. This further motivates CODESAs to encourage community members to take advantage of the health center.

Through these incentive programs, IHP has also stimulated a more proactive role for CODESAs to become instruments for social accountability to a degree that was not clearly articulated in the

[17] I S. Sadaphal, A. Bongiovanni, Promoting Access to Quality Health Services: A Midterm Assessment of a Results-Based Financing Intervention in the Democratic Republic of Congo. International Business & Technical Consultants, Inc. (IBTCI), 2015, p. 4. In addition, CODESAs receive up to 10% of the funds allocated under RBF to high-performing health centers, which is more than the small monthly stipend allocated to all CODESAs for their monthly meetings.

original Project concept. Specifically, as reported by at least two CODESA presidents, the CODESA president is present during the arrival of drug stocks, both at the health zone headquarters and at the health center, to verify quantities. A number of CODESA leaders also expressed awareness of the amount of the RBF performance grant to the health center when it meets its targets, and were aware of how these funds are spent. By participating in provisioning, and to some extent, in overseeing the management of the health center, CODESA members expressed a sense of partnership with the health center and motivation to carry forward their work in the community. Finally, IHP has further stimulated the management functions of the CODESA by ensuring that one of the CODESA presidents, who are selected by all the CODESA presidents in the zone, attend quarterly management meetings at the level of the health zone to review performance indicators and operational plans of action. Some CODESA presidents have also participated in the LDP provided to health service managers.

Health Center staff corroborated many of the comments of CODESA members. Some of the staff expressed the belief that, while there is some variation in the capabilities of CODESA members, there are a number who are very dynamic, creating a spirit of collaboration between staff and the CODESA.

Champion Communities

As described in the MSH Technical Application, IHP continued the Champion Community approach begun in DRC under a USAID-funded Leadership, Management and Sustainability (LMS) Project[18] as a means to support health advocacy and community mobilization organizations for purposes of Behavior Change Communications. The approach is conceived as a participatory framework used to create a platform for communities to identify and respond to local health challenges. It is also envisaged to be a means of leading the community in awareness raising, behavior change campaigns, and health education activities— all forms of health promotion. The first Champion Communities were launched in 2012; by the end of the project, 34 Champion Communities had been supported.

Relative to a CODESA, which is a standing committee associated with a specific health sub-zone, the creation of a Champion Community requires community members to volunteer to form a group, and a single Champion Community normally works in more than one health sub-zone. On the basis of briefings to community members by health zone and IHP staff, a Champion Community is formed by community members, who volunteer to create and implement a health advocacy plan that usually focuses on a targeted theme. Following a six-month period of interaction with IHP and health service staff, receipt (by the Champion Community coordinator or steering committee) of targeted training in advocacy and often in a specific technical area, and completion of its action plan, the Champion Community receives a US$ 500 grant from the Project to carry out its plan.

Although Champion Community leaders may not have been previously associated with the health sector, they are normally influential members of the community, like pastors or teachers. The identification and selection process for Champion Community leadership is likely to result in a higher degree of dynamism on average than that characterizing CODESA leadership, which is rooted in CHWs who “rise through the ranks.” (CODESA presidents are elected by fellow CHWs, and it is likely

[18] The Champion Community concept originated in a program in Madagascar but was adopted and adapted by MSH to fit the context and needs of the Congolese health system in the IHP catchment areas.

that they may in some cases be selected through seniority rather than dynamism, depending on the social norms of the community.) Champion Community leaders also receive more training than CODESA leaders, and the Champion Community action plan is focused on a particular time frame of targeted activity relative to the CODESA's ongoing work plan over a more indefinite period.

An assessment of the Champion Community program conducted in June 2015 provided data on two communities that were also visited by the author. These Champion Communities showed impressive results in achieving their action plans over a short time period, as shown in Table 2, "Results of Champion Community Collaboration in Two Health Sub-Zones."[19] Because Champion Community action plans are developed by each sub-zone and are therefore specific to that community, it is not possible to aggregate data on improvements generated by Champion Communities or to compare it with communities that did not have Champion Communities.

Table 2: Results of Champion Community Collaboration in Two Health Sub-Zones

	Percent of Population	
	Before (8/2014)	**After (5/2015)**
Bakwabowa Sub-Zone/Health Center		
Diarrhea incidence	25%	8%
Ante-natal care: 4 visits	67%	96%
Mosquito net use by household	20%	75%
Latrines: percent of households in community	22%	68%
Kabuela Sub-Zone /Health Center		
Assisted delivery	14%	32%
Mosquito net use by household	25%	57%
Latrines: percent of households in community	23%	89%

These results for two sub-zones were corroborated by an analysis undertaken (as part of the final Project evaluation) subsequent to the data collection for this case study.[20] The analysis sought to investigate whether the introduction of innovations like Champion Communities was associated

[19] Lynn Lawry, Evaluation of BCC Activities Implemented by DRC-IHP: Trip Report May 19-June 6, 2015. Overseas Strategic Consulting Ltd. (OSC). Data presented in Table 1 were titled in the evaluation (and in the IHP April-June 2015 Quarterly Report) as "Kanda Kanda Health Zone" and "Kabuela Health Zone" respectively. Kanda Kanda is a *health zone* comprising 12 *sub-zones*, two of which are Bakwabowa and Kabuela sub-zones from which the above data are taken. The Champion Community that serves the two health zones shown in the table works in one other sub-zone of Kanda Kanda health zone; as such, its reach is one-quarter of the 12 sub-zones in the Kanda Kanda health zone, not the whole zone. Reporting these as results for an entire health zone therefore overstates the impact of the Champion Community.

[20] B. Salumu (2015), Analyse des Stratégies du PROSANI et Autres Déterminants de la Performance des Zones de Santé Dans Quatre Provinces de la République Démocratique du Congo de 2010 à 2015, Evaluation Report, unpublished. Multivariate analysis (logistic regression) was applied to highlight the chance that benefitting from a particular strategy or innovation individually or collectively, led to higher health zone performance than in those that did not benefit from the strategy or innovation. This comparison was done for each selected indicator after statistically grouping (using k-means algorithm) all health zones into two classes (high performing vs. low performing) depending on the average result achieved in relation to the relevant indicator. The study acknowledged that findings should be viewed with caution as they reflect an association, not causation.

with performance on a particular Project performance-monitoring indicator. This analysis showed that compared to health zones without the approach, health zones with Champion Communities were more than twice as likely to have high performance on: (1) the number of new acceptors of modern contraceptive methods; (2) the number of family planning/reproductive health counseling visits; and (3) the percentage of pregnant women attending at least four antenatal consultation visits. The Champion Communities approach was also positively associated with improved performance in the number of cases of child diarrhea treated.

The results of the end-Project analysis and examination of the two health sub-zones cited in Table 2 reflect important gains achieved through the efforts of the Champion Community. However, based on knowledge gained from the author's visit to the two sites above, attribution of outcomes solely to the Champion Community needs to be viewed with caution. Some of the increases in positive indicators were associated with concomitant provision by the Project or partners of other inputs, such as mosquito nets, materials for latrines, and mHealth messages. The Champion Community associated with these achievements had not yet received a grant from the Project because it had not yet finalized its action plan, and it had only been operating for nine months. It was therefore not yet officially "declared a Champion Community," so its independent "ability to deliver" was probably not at full strength. (Although it could be argued that this makes its achievements all the more remarkable.) And, possibly most important, the CODESAs for the associated sub-zones and health centers appeared to be relatively dynamic, and a number are members of both the CODESA and the Champion Community.

CODESA and Champion Community Members with
Bakwabowa Health Center Staff, Kanda Kanda Health Zone

In fact, the author's interviews and joint meeting with members of the CODESA and Champion Community serving Bakwabowa and Kabuela sub-zones revealed a high level of energy and activism in both. This may partially relate to the membership in each — e.g., the Champion Community coordinator is a pastor; the CODESA president is director of a primary school, and a number of dynamic CHWs serve on both. When asked about whether their functions were duplicative, informants reiterated that their work was synergistic: the CODESA members have direct ties to specific neighborhoods and households as well as an ongoing relationship with, and continuing presence at, the health center. The Champion Community likely also has greater access to public forums like schools and churches.

What is clear is that important gains are being achieved by these mutually reinforcing interventions. And dynamic Champion Communities in other locations are reported to be demonstrating increasing

ingenuity and autonomy. In Bukavu, one Champion Community raised the equivalent of US $11,000 to initiate building a health center, which the government completed. Four Champion Communities have formed a consortium to generate and leverage funding. Under the guidance of the Project, 23 of the 34 assisted Champion Communities have received NGO status by the government, which will allow them to solicit funds from other sources; the remaining Champion Communities are in the process of finalizing their applications.

IHP staff report some challenges facing the Champion Communities, some of which are also common to CODESAs. They include: variation in capacity and commitment; insufficient supervision by health zone management; inexperience in presenting programs and writing grants; and challenges when attempting to target specific audiences for creation of sub-groups. The June 2015 evaluation of Champion Communities recommends a number of measures to enhance the effectiveness and sustainability of Champion Communities. These include: encouraging health center staff to continue to provide technical support; making a point of selecting Champion Community coordinators who offer vibrant and self-motivated leadership; and integrating Champion Communities with other programs like CUGs (discussed in the following paragraph) and mHealth in order to reinforce health messages.

Closed User Groups

Closed User Groups (CUGs) were introduced by IHP in mid-July 2012 in 7 of the 80 health zones as part of its behavior change communication (BCC) activities, in association with a cell phone (SMS)-based "mHealth" initiative. These were conceived as a joint program to leverage cell phone–based communications to send and receive health messages. The CUGs were designed to increase the reach and frequency of BCC messaging and to support dialogue among community members about health concerns and behaviors. Cell phones were distributed to about a dozen selected health service personnel and people chosen by the community in each location. Community members with a health question or who sought follow-up on the recommendations of an mHealth message conveyed by text message could contact one of the phone holders, who could in turn contact health personnel at the local health center. The program focused largely on downward transmission of information to citizens, with the emphasis on opportunities for the latter to request clarification or further information, rather than on two-way exchange or consultation, although the latter was not excluded.

A combined evaluation of the CUGs and mHealth program undertaken in 2013[21] reported that the data collected for these "did not meet the level of quality and reliability necessary to draw conclusions about the MHealth and CUG programs with a high degree of confidence in all instances." However, it reported positive responses in some communities where the network of CUG members was strong: 64 percent of participants in focus group discussions expressed enthusiasm for these initiatives. CUGs were credited with helping the community solve a range of health issues, including some that were pressing as well as longer-term concerns related to the household or community. Some community members expressed a sense of empowerment to take

[21]Overseas Strategic Consulting Ltd (OSC). An Assessment of the Integrated Health Project's SMS Campaigns and Community-Based Closed User Groups. OSC. 2013.

on responsibility for the CUG phones, and correctly recognized the communal nature of the phones.[22]

As noted in the evaluation and corroborated by an assessment undertaken in June 2015,[23] challenges arose in a number of areas, some of which are characteristic of those affecting SMS-based information sharing more generally. In particular, while messages were generally focused on women's health issues, it was difficult for women to access these messages because men tended to be the holders of cell phones and have a higher literacy rate than women. The Project suspended CUG activity in January 2015 due to an increase in mobile phone rates. While these rates are being renegotiated and the program may recommence, the latest evaluation suggests that the sustained motivation of these groups may be better ensured if they are associated with the Champion Communities and would benefit from close collaboration with health zone personnel. However, the 2015 evaluation reported concerns about the sustainability of the program after IHP ends.

Client Satisfaction Survey

An instrument for citizen feedback that does not appear in Project implementation reports but that may hold the potential for providing useful information is the client satisfaction survey that forms part of the assessment methodology of the RBF program.

The RBF intervention introduced in seven health zones of the Project in late 2013 includes a client satisfaction survey as part of the program to provide financial incentives for health districts and health facilities to achieve mutually agreed-upon targets that are linked to quantity and quality of services, community engagement, and resource management. The rating system gives points for 20 indicators, including one for patient satisfaction measured through the survey. The client satisfaction survey accounts for 10 percent of the health center's total score.[24] As part of their counter-verification responsibilities, local NGOs are recruited to conduct a survey of patients selected at random from the health facility's roster of patients seen the previous quarter.
The author met with representatives and field survey staff of the two NGOs that carried out the surveys in Bibanga Health Zone. They reported that some of the challenges in undertaking the survey included: locating patients due to imprecise recording of names when registering at the health center; transience of some patients; and initial suspicion of outsiders asking questions. However, response rates rose in subsequent surveys as survey teams gained experience and communities became accustomed to their visits.

Results from a March 2015 client satisfaction survey for 12 health centers in Bibanga Health Zone revealed favorable responses on a number of key indicators, including: general quality of care; availability of health personnel and drugs; fees; waiting time; cleanliness of the health center; and absence of discrimination by income or gender. The lowest responses, in descending order, related to: (1) not receiving a card that would permit a free follow-up visit at the time seen; (2) knowing

[22] The analysis cited above that measured outcomes associated with Champion Communities [provide see footnote 21] also noted positive association between the mHealth message approach and improved performance on a wide variety of health performance indicators. Since SMS messaging constitutes a form of information dissemination as part of health promotion, it does not constitute citizen engagement and was not in the scope of work for this case study.
[23] Lawry, op. cit.
[24] IHP. Manuel du Financement Bases sur les Resultat—PROSANI. April 2013.

about their CODESA and whether they benefit from its activities; and (3) receiving advice from health center staff.

The medical chief of Bibanga Health Zone reported that the survey results are discussed at the quarterly health zone management meetings attended by the head of each health center and a CODESA president. The discussion focuses on the summary provided by the NGO survey team of the three to five areas for improvement at each center. The author observed that the survey results were not posted with other RBF results in the conference room of the Bibanga Health Zone offices, and representatives of CODESAs and health centers did not seem to know much — if anything — about the survey when queried, mentioning instead the suggestion boxes that several of the centers have established.

Based on survey results to date, it is possible that, because the key areas of health service quality and responsiveness are already being addressed, the survey does not attract much notice. In addition, there may be methodological issues with how the survey is conducted that might suggest that an exit survey would provide more information. If RBF and associated client satisfaction surveys are to be included in future health projects, the Project design team, and subsequently Project and health zone leadership, should evaluate the survey to determine if more information can be gleaned from it than is now the case, since it could be a useful tool for feedback and management improvements.

Governance at Zone and Provincial Levels

As articulated in IHP's sub IR 4, in regard to "improved health sector leadership and governance in target provinces," one component calls for "community involvement in health policy and service delivery [to be] institutionalized," especially in provincial planning and budgeting, by "including unions, professional associations, rights groups and, other relevant civil society leaders." [25] The Project design also called for strengthening the advocacy skills of CODESAs. In association with strengthening the strategic decision-making skills of health sector personnel, this citizen engagement intervention targeted the social accountability role that citizen groups could play to strengthen sector governance.

Apart from a brief mention in the Project work plan for Year 5, the citizen engagement element of provincial governance support does not appear to have been targeted during Project implementation. Quarterly reports focus on supply-side strengthening programs like the capacity building program, the LDP for health managers, which is reported to be effective and appreciated. The Kasai Oriental provincial Ministry of Health (MoH) holds a semi-annual steering committee meeting chaired by the regional MoH, which includes participants from civil society as well as donors operating in the province. The provincial division chief, who serves as Secretary to the steering committee, reported that the provincial MoH finds these steering committee meetings to be a useful forum to meet with partners, and cited two NGOs that participate in them. However, meetings with representatives of these organizations[26] revealed that their capacity to serve in a social accountability role is very limited. One of them, the regional arm of a nonsectoral civil society advocacy organization, stated that the MoH makes decisions unilaterally, but she was not able to

[25] MSH, op cit., p. 20.

[26] Kasai Oriental provincial branches of: Societe Civile de Kasai Oriental (SOCIKOR) and Conseil National des Organisations Nongouvernmentale de Sante (CNOS).

speak to specifics, and appeared to know very little about what is happening in the health sector. The second, a collective of local health NGOs, has such limited means and capacity that its representative was not able to produce a list of its members during a meeting with him. He stated that his organization is not always invited to the semi-annual steering committee meetings. When it is invited, he said, it uses these meetings essentially to request financing or commodities from the MoH on behalf of its constituents, requests that he reported are directly referred to the donors by the MoH.

Further, it does not appear that the provincial administration, which is under the authority of the Ministry of the Interior, exerts an accountability role on the regional MoH, as it does in other countries where authority is decentralized to provincial administrations. The Vice Mayor of Mwene Ditu, the second largest city in Kasai Oriental, sees the role of administrative authorities as being to mobilize the population "to listen to what the MoH is telling them and to do what they say," not to challenge the MoH to improve its performance or increase resource allocation.

The principal reason why these accountability mechanisms do not work — and why the IHP has probably not pursued them — is that the MoH is highly centralized, with authority residing in Kinshasa. As a result, the provincial level entities — including the regional MoH itself — are likely to have limited authority over the volume or geographic allocation of resources, and they therefore have relatively little power to affect in a meaningful manner how resources are used.

These challenges notwithstanding, the usefulness of these meetings and the supportive role that IHP plays in them is a means for coordinating donor inputs of drugs, commodities, and equipment so they are distributed in a rational manner across the province under regional MoH leadership. In this regard, they are effective in avoiding duplication and developing strong collaboration among the regional representatives, including IHP's, to ensure effective use of resources.

Spectrum of IHP Citizen Engagement Instruments and Relation to Theory of Change

The implementation of the above five citizen engagement instruments largely validates the role they were to play as depicted in the Project's theory of change. In some cases, their role evolved over time in terms of where they stand on the spectrum of citizen engagement presented in Figure 2 (page 7), suggesting that their contribution to Project results may have evolved over time or will do so in the future.

Analysis and key informant interviews related to the first three instruments described above — CODESAs, Champion Communities, and CUGs — confirmed their role as ***citizen interface groups***, as shown in the theory of change. They contributed to citizens or communities seeking improved health seeking behaviors, leading to more referrals and use of health centers, as well as improved health practices. The analysis in the preceding paragraph validates the placement of the CUGs on the spectrum of the citizen engagement instruments as leaning toward information provision. They tended to focus largely on referral and some dialogue more than on seeking citizen feedback.

The CODESAs and the Champion Communities played a much more active role in consultation and participation of citizens to determine appropriate health-seeking behaviors and to shape the interventions by health services in providing support for these practices. In fact, having started as a vehicle for health BCC, with a heavy emphasis on information campaigns, the Champion Communities are moving progressively toward empowerment in the sense of establishing

independent NGO status and developing action plans. Some of these may shift them outside the health sector — for example, by developing independent sources of income, generating the potential for remuneration, and pursuit of contractual services that could be of use in other sectors.

Some CODESAs are moving beyond being citizen interface groups, becoming stronger as more genuine ***accountability groups***, as shown in the IHP theory of change, although this role had been given less prominence at Project inception. The citizen satisfaction survey is considered a structured form of consultative feedback, with potentially more validity and use as an instrument of accountability than may characterize more informal consultation. Finally, the use of provincial citizen groups to strengthen health sector governance is clearly a social accountability tool that, unlike the IHP's other citizen engagement instruments, was not able to realize its objective to serve an accountability role.

Contribution of Citizen Engagement to Project Results

Influence of Citizen Engagement on Overall Project Results

Given the challenging country context in which IHP was implemented, the Project made significant progress in achieving its targets. By the end of June 2015, three months before the formal Project closing date, nearly 70% of its 83 indicators had achieved their targets at the 75% or greater level, and 43% performed at over 100% of their target.[27] For 6 of the 8 provincial coordination offices, [28] utilization rates for curative services reached 47%, an improvement over the national average of 35%; the other two coordination offices exceeded that same national average for the first time — climbing to 38% and 41%, respectively by mid-2015. Project staff attribute the increase in referral rates, which exceeded targets by a multiple of 3, in part to community awareness campaigns and capacity and skills of CHWs to engage with communities more effectively. The end-Project evaluation[29] also confirmed a positive association between Champion Communities and mHealth text messaging initiatives with health zone performance .

However, the findings of this case study confirm the expectation set out in the Scope of Work that "direct attribution of any Project outcomes solely to the citizen engagement intervention [is] not possible." And because in virtually all Project sites, multiple citizen engagement instruments were introduced concurrently, it is also not possible to isolate the relative strength of one over another; in locations where Champion Communities were introduced, for example, they are likely to have members who are also members of CODESAs, with the strengths of each instrument reinforcing

[27] DRC-IHP Quarterly Report: Year 5, Quarter Three (April to June 2015), p.9.

[28] Some provinces have more than one coordination office necessitated by transport constraints.

[29] B. Salumu (2015), Analyse des Stratégies du PROSANI et Autres Déterminants de la Performance des Zones de Santé Dans Quatre Provinces de la République Démocratique du Congo de 2010 à 2015, Evaluation Report, unpublished. Multivariate analysis (logistic regression) was applied to highlight the chance that benefitting from a particular strategy or innovation individually or collectively, led to higher health zone performance than in those that did not benefit from the strategy or innovation. This comparison was done for each selected indicator after statistically grouping (using k-means algorithm) all health zones into two classes (high performing vs. low performing) depending on the average result achieved in relation to the relevant indicator. The study acknowledged that findings should be viewed with caution as they reflect an association, not causation.

both. Moreover, the Project did not include baseline data, design features, or control groups to test the role of the citizen engagement instruments.

Results from the client satisfaction survey and discussions with key informants suggest that factors outside those related to citizen engagement were the principal contributors to increased use of health services. First among these is reduction in fees, which resulted primarily from the introduction of the RBF that injected cash and commodities into the health centers, allowing them to pay their staff — many of whom receive no government remuneration — and provide free drugs, and to thereby reduce fees.[30] Fee reduction was, without exception, the number 1 reason cited for increased use of services, corroborated by the infrequency with which the client satisfaction survey respondents complained about fees. Other positive responses on the client satisfaction survey — such as availability of staff, short waiting times, and cleanliness of premises, could theoretically have resulted solely from supply-side measures to improve quantity and quality of services, not from demand generated by citizen engagement measures.

That said, some conclusions can be drawn from comments of the NGOs that undertook the client satisfaction survey and counter-verification of health center performance based on additionally solicited opinions about the health services expressed by patients who presumably did not have a vested interest in reporting citizen feedback biased toward unduly favorable reactions. The voluntary observations of citizens queried suggest that: (1) citizens perceive not only that the quality of services is rising, but that the health center is "our" center; (2) CODESAs are more dynamic (although this is not corroborated by specific survey feedback); (3) patients are perceived by health center personnel as equals; and (4) people speak of "community health" (*la santé communautaire*) as a collective good. CODESA members also reported that now that the public sees that fees can be reduced and some CODESAs feel that they have an influence on setting those fees, it will be much harder for centers to raise their rates in the future. There may even be some competition between centers to keep rates in line; staff at one center reported that they would not be able to raise rates because people would go to the health center down the road that had lower rates.

Factors Contributing to Positive Citizen Engagement Results

Several factors contributed to what are likely to have been positive results in implementing citizen engagement approaches and thereby permitted citizen engagement to contribute to positive Project results:

- *The IHP project design made "people-centered" approaches integral to many of the Project's components* beginning with the overall vision and conceptual framework related to empowerment, attitudes, and motivations.
- The *approach of BCC emphasized "talking with" — not "talking to" — citizens* in discussing with target constituencies their motivations for changes in health behaviors, including extensive use of "Education through Listening" (ETL) to encourage health services to engage in dialogue with citizens "to promote internally motivated health behavior change. . . Under ETL the paradigm shifts from lecturing to personal and community participation for problem solving" through use

[30] Even at sites where RBF was not introduced, IHP coordinated with other donors or through other projects (Pathfinder, Unicef HPP) to inject commodities and/or cash into health zones.

of community mapping, collective identification of community health problems, and design of action plans with training in specific health endeavors that emerge from community priorities.[31]

- The *Project included both supply (*improving quantity and quality*) and demand* (nurturing citizen consultation, participation and feedback) *components,* which reinforced each other. Research indicates that citizen engagement measures need to be accompanied by improvement in services in order to be effective.[32]
- Beyond promoting supply and demand, the *RBF created further incentives to involve community groups*, particularly the CODESAs, in performance enhancement, and to monitor client satisfaction. While this was confirmed in the midterm assessment of RBF cited earlier, even a separate global evaluation on RBF that called into question the impact of RBF in many countries found that evidence supports the efficiency of RBF in DRC.[33]
- The *LDP provided motivational support and skills* to both health service management and selected citizen leaders to find common solutions, with its emphasis on converting constraints into problems for which solutions could be devised.
- The *IHP staff provided considerable implementation sup*port, particularly through verification required under RBF.
- *Communities may be incentivized to solve their own problems* when confronted with opportunities presented by the Project, knowing that the government will not do it for them.

Constraints to the Contribution of Citizen Engagement to Project Outcomes and Sustainability

While many of the positive Project outcomes can be attributed to the above factors, two factors work against sustainable contribution of these citizen engagement initiatives and, more generally, the sustainability of Project outcomes. These relate to the poverty among a large share of the population and to the weak governance situation in the country.

The extreme poverty and low level of economic activity among many of the Project communities make it difficult for citizens to commit a great deal of time to volunteer. Volunteer fatigue has been a constraint raised in Project reports. It is indeed remarkable that CHWs and CODESA members commit as much time as they appear to do when living in such modest circumstances. The provision of small incentives by the Project has stimulated them, raising the risk that without these, it would be difficult to maintain their motivation. The capacity of some Champion Community members is also quite weak, and NGO status of the Champion Communities — while theoretically promising in terms of sustainability — still requires that there be funding sources to sustain them. This invariably depends on donors, so these cash-strapped entities may need to "follow the money." As there is a great deal of donor interest in the health sector, it is hoped that these donors will enable continued support to Champion Communities. However, if this support does not materialize in the communities where Champion Communities have been created, they may seek opportunities outside the health sector, which could lessen their ability to continue to undertake community mobilization for health.

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[31] MSH, op. cit., p. 6.

[32] Mansuri et al., op. cit., p. 200.

[33] Soeters et al., 2011, in Amanda Grittner, Results Based Financing: Evidence from Performance Based Financing in the Health Sector, Bonn, German Development Institute, p. 41.

Above all, the enabling environment related to governance creates a chronic constraint to sustained impact of Project impacts, including those in favor of or induced by citizen engagement. The highly centralized Ministry of Health and low level of funding for health services inhibit the creation of local social accountability measures. A constitutionally mandated decentralization of government services is proceeding slowly, and MoH provincial units do not yet match the new administrative provincial boundaries. Moreover, with elections planned for the coming year, further decentralization progress may be slow.

Even a centralized Ministry of Health can only do so much to increase the proportion of overall government revenues devoted to health services. And it is not certain that MoH officials fully appreciate the role that citizens already play in financing their own health. Based on a brief discussion with a MoH representative, it appears that the MoH attaches importance to community participation in that the MoH "counts on the population to ensure that health goals are met." He commented that "the government has not yet convinced the population of the role the community needs to play," observing that if the amounts the public pays to health centers were instead allocated to public revenues through tax payments, the government would be in a position to finance the health sector.

Until government is able to provide the funding and governance structure to support the health of its citizens, the need for donor funding and the already considerable self-financing by the public will persist if Project measures across the board are to be sustained.

IV Conclusions and Recommendations for Future Programming

Many of the factors that contributed to the success of citizen engagement interventions in IHP were the result of strong design and vigilant implementation monitoring that are the hallmarks of sound health projects across a range of country environments. DRC presented a particularly challenging environment because, despite their poverty, citizens are responsible to a much greater degree than elsewhere for financing their own health costs due to the low funding by the DRC government for health personnel and drugs.

In this context, IHP took an approach in which citizen engagement mechanisms initially substituted to some extent for government, serving as extensions of the health system. For example: CODESAs were to mobilize community resources and serve as a referral system; Champion Communities were to deliver information campaigns; and CUGs leveraged the transmission of health messages via SMS and provided referral services. However, thanks to an emphasis on dialogue and building the capacity of these groups, IHP enabled two of them to expand their mandate to include accountability, in the case of the CODESAs, and empowerment, in the case of the Champion Communities (and to some extent, the CODESAs, too).

Experimental approaches combining user groups (CUGs) and SMS messaging explored the potential for greater use of information and communication technology, which could be further developed in future programming for both message transmission and accountability. Structured feedback instruments, like the client satisfaction survey, introduced the potential to strengthen feedback to health services to improve management of service delivery. Efforts to use citizen groups to improve accountability at the regional level were not vigorously pursued; in any case, they are unlikely to be

successful in the DRC context, where MoH or local government authority at provincial level is limited, and donors are both supplying and directly managing the resources (e.g., drugs and commodities), thereby ensuring their own monitoring of these.

The design considerations that emanate from the IHP experience are applicable across a range of country contexts. However, they are particularly focused on what is likely to be most effective in future programming in a country like DRC, and are therefore directed to donors and those undertaking health program development in this country context. They focus specifically on the recommendations for incorporating and ensuring the success of citizen engagement interventions, as described below:

- *Ensure strong analysis up-front of community characteristics* to tailor interventions to the local context. IHP undertook a number of community assessment or mapping exercises to fine-tune design of specific components.
- *Include both supply and demand components* in the Project. IHP's support to increase access and quality of health services, while concurrently strengthening citizen engagement instruments, promoted synergies that contributed to the successful implementation of both. The experience elsewhere is that relying solely on citizen engagement measures to effect change rarely produces discernable benefits.
- *Consider use of results-based financing* to incentivize both health service providers and citizen groups. Particularly with the financial constraints confronting local health centers in DRC, the RBF commodity and cash incentives provided significant impetus to improve services, and they permitted donors to directly monitor implementation. While the latter is a second-best alternative to oversight by government itself, it is necessary on at least a temporary basis in situations characterized by weak governance.
- *Include citizen engagement measures that foster both consultation/participation and social accountability* where possible. The development of the latter — as was the case when the CODESAs became more involved in management oversight of RBF funding — can stimulate a greater sense of ownership by communities.
- *Introduce structured feedback mechanisms as a tool to improve management.* The client satisfaction survey introduced as part of RBF holds the potential to be more thoroughly mined to strengthen management of health services.
- *Develop the awareness and capacity of health services to work with citizen groups.* Leadership training directed at provincial and zone level gave health service leadership an appreciation for the potential role of citizen groups like CODESAs, leading health zone directors to perceive that CODESAs could contribute significantly to the sustainability of health improvements supported by IHP.
- *Use existing citizen groups*, in cases where these are esteemed members of the community, to help ensure sustainability. While CODESAs have mixed track records, they are standing entities whose members are selected by their communities, and they will continue after Project completion.
- *In supporting citizen user groups, focus on trust building and dialogue,* rather than using these strictly as conveyers of health information. IHP's Education through Listening put the emphasis on talking with, not talking at, communities.
- *Consider use of information and communication technology like SMS to enhance distribution of messages* (as well as serve as a tool for social accountability) *in association with other citizen engagement measures*. Use of CUGs in conjunction with text messaging will need to be explored

in future health projects; a growing body of literature on the use of mobile technology should be consulted.

- *Establish monitoring mechanisms that include measures to assess citizen engagement*. IHP has several of these, and while they may have been imperfect, they helped Project staff remain focused on community participation.
- *Include provision in Project design for impact evaluation correlating citizen engagement measures with health delivery or outcomes.* It is not realistic to include within the Project large-scale evaluations using randomized control trials, but projects should attempt to anticipate the kind of baseline data that will be useful so that end-project evaluations can correlate citizen engagement and project outcomes.
- *Include sufficient budget for operational advice to field staff and for monitoring citizen engagement implementation.* IHP assigned a community mobilization specialist to each coordination office to assist in these tasks.
- *Continue the macro-level dialogue with government*, in partnership with other donors, *to strengthen governance in health sector delivery* more generally, *including support for national-level NGOs to lobby for pro-health measures and a greater citizen voice.* This dialogue is likely to be beyond the scope of an individual project, but it is essential to the long-term sustainability of measures to promote health service delivery and governance.

The positive results in implementing citizen engagement approaches in IHP validate the desirability of ensuring that Project design weaves "people-centered" approaches into most or all of a project's components, with emphasis on dialogue, consultation, and participation. The other key contributor in a context such as DRC is to ensure the inclusion of measures to strengthen both the supply (quantity and quality) of health services and the demand (citizen interface groups as well as accountability measures) for health services. Despite sustainability challenges presented by the DRC enabling environment, donors need to frame the content and duration of their investments to support the long-term process of building the Congolese health system and equipping citizens to improve their health practice, in order to enable the people of the Democratic Republic of Congo to experience better health outcomes.

Appendix A: Original Scope of Work

Scope of Work
Two Case Studies on Successful Strategies for Engaging Citizens in Health Activities

Dates: May 1, 2015 – September 30, 2015

A. Overview

The USAID-funded Leadership, Management, and Governance (LMG) Project at Management Sciences for Health (MSH) seeks an applicant to explore how health interventions can be enhanced through the active engagement of community members using case study methodology. The objective of this discrete research activity is to document two examples of health projects that include citizen engagement interventions in the health project design to increase the evidence base on how citizen engagement influences health program implementation and outcomes — including lessons learned, best practices, and recommendations for future programming.

The applicant will investigate three pre-selected country case studies (in Perú, Haiti, and the Democratic Republic of the Congo) where citizen engagement was a key aspect of a USAID-funded MSH health project. Each of the three potential cases identified include citizen engagement interventions as part of a larger health project with a range of interrelated health interventions contributing to project results. This makes it impossible to directly attribute any project outcomes solely to the citizen engagement intervention. Based on their initial screening of these three case studies, the applicant will select two of the three examples to examine how the citizen engagement elements of the activity contribute to Project results. Their selection criteria will likely be based on data availability, estimated costs, and logistical considerations.

For the two selected case studies, the applicant will document the Project activities and its results or (anticipated results) using qualitative case study methodology, which will include: a targeted literature review of relevant citizen engagement interventions in the health sector; analysis of program-monitoring data; and key informant interviews with community leaders, government officials, program managers, and patients. For research practices and methodologies guidance, the applicant should reference Robert K. Yin's *Case Study Research: Design and Methods (Fourth Edition*).

The final product will consist of a targeted literature review (10-15 pages), two case studies on the selected projects, and two abbreviated versions of the case studies intended as how-to guides to inform future programming. The two case studies should include theories of change, detailed implementation steps, challenges, best practices, and recommendations for future programming. For guidance on case study format, please reference the USAID-funded AIDSTAR I Case Study Series. (See link http://www.aidstar-one.com/resources/case_study_series.)

The intended audience for the proposed document will be public health stakeholders including policy makers, health program managers, and community leaders. It is also aimed at technical advisers who can use the findings to inform the design and implementation of health activities that can engage community voices and leadership in project design, implementation, and monitoring to improve program outcomes. The applicant will explore whether relevant government bodies for each case study will grant permission to make public any relevant data so it could be accessed and used for additional analyses.

B. Statement of Work

The research activity will likely include the implementation steps below. Applicants are encouraged to put forward alternative approaches when accompanied by clear rationale for improved research quality and effectiveness.

Expected Level of Effort	Anticipated Implementation Steps
3-4 weeks	• Conduct introductory interview with client and agree on implementation approach. • Conduct initial briefings with case study points of contact to understand the context for the intervention, objectives, health activity design, and data available. Select two of three examples to examine how citizen engagement elements of intervention influenced Project results, in coordination with the client. • Develop literature review to clarify term definitions (such as citizen engagement/community involvement) and provide an evidence base and context for each of the case studies.
3-4 weeks	• Draft and submit research design and plan, including: methodology, interview tools, draft interview schedule, and outline of case study reports. • Plan field visits and schedule interviews with key informants.
6 weeks	• Conduct field visits for the two selected case studies to conduct key informant interviews and beneficiary interviews, and collect and verify program monitoring data.
4 weeks	• Analyze data and draft case studies for review.
2 weeks	• Incorporate feedback from client, finalize case studies, and draft 4- to 5-page briefers with main findings.

C. Deliverables

The above-described activities will culminate in the production of the following:
(Note: Due dates are forthcoming.)

1. A proposed research design, including research question(s), key informant tools, theory of change for each case study, and report outline;
2. A targeted literature review on citizen engagement (10-15 pages);
3. Two case studies of approximately 15-20 pages with overview, visual graphics, general implementation steps, main findings, and recommendations for future programming. Interview questionnaires and other tools from field visits will be included as appendices.
4. Two abbreviated 4- to 5-page how-to guides for each case study designed for donor community and other relevant stakeholders, with a focus on future program design and implementation recommendations.

Appendix B: IHP Interview Protocol — Lines of Inquiry

The researcher will meet with a cross section of the representatives of the parties represented in the boxes in the Project Theory of Change to gain perspective on each on the program or components in which they participated.

These **key informants** include:

- ***Representing "supply:"***
  - Ministry of Health at national level
  - Provincial and/or health zone MoH representatives
  - Local government (outside health sector)
  - Personnel at health centers
  - Persons delivering the training or sensitization of community/citizen representatives

- ***Representing "demand:"***
  - Community leaders not directly involved in the program (i.e., elders)
  - NGOs/CSOs functioning at the local level that had some connection to health or citizen activism — either in association with IHP or separately
  - Persons who played leadership roles in different groups (e.g., CODESA, management committees [COGES], Community Champions, Closed User Groups, various women's/youth groups)
  - Community distributors (community health workers)

- ***Representing project/donors***
  - Key IHP staff
  - MSH representative
  - USAID point person
  - Any other donors who could provide a useful perspective on the enabling environment or involvement in similar programs

The following are **general questions/topics to be discussed**, each of which would be tailored to the perspective of the informant, based on the nature of their involvement. Questions will be asked in a relatively open-ended manner to avoid suggesting what might constitute a desirable answer.

- Was there awareness of efforts under IHP to support citizen engagement measures?
- Was there support for the concept of citizen engagement?
- In regards to support for the measures being undertaken under the project: Were goals realistic? Was the design sensible? Was implementation well handled? Why or why not?
- Discuss the motivation of the different partners (local government, MoH, citizens) to engage in the efforts. How committed or responsive were they?
- How were citizen leaders selected? What kind of leadership did this result in? Should other selection criteria and processes been used?
- Discuss the competence/capacity of different partners to engage in the efforts.
- Did the program provide the group members with the tools they needed to achieve the objective of the group? Please elaborate.

- In regards to dynamics of the groups, discuss the compatibility of group members and their ability to develop consensus. Was there domination by any single party? Was there capture of benefits by any members? Were there favored relationships with health personnel?
- Discuss the trustworthiness of different partners. (This topic should be broached in a very indirect manner, usually by following up delicately on comments made in response to other questions.)
- What were major barriers/constraints? Please elaborate.
- Have you seen any changes in health behaviors of citizens who directly participated? If not, why not? If so, please specify?
- Have you seen any changes in "health-seeking behaviors" of citizens more broadly who did not participate directly in the program? Please specify.
- Has the relationship between citizens and traditional healers changed? How?
- What is the incentive for increased use of health services/visiting health centers if services are on a "pay" basis or if staff/supplies are lacking? Is failure to visit a health center due to motivation or means? Has the Project improved the supply situation? How?
- Was there actual or perceived evidence of improved health practices and/or improved health outcomes?
- Do you consider the program a success? How was that success defined? How was the success manifested?
- If the outcome was positive, what factors were key for success? Which were in place or came into play during implementation? Which were not in place or did not come into play then?
- Are these efforts and groups likely to carry on after the completion of the project? Why or why not? If the latter, is there anything that would stimulate (or could have stimulated) sustainability?

Questions regarding specific citizen engagement approaches: Education through Learning, mHealth (text messages), media, other training (should WASH and BPF be included?):

- Was the design appropriate? Was it targeted to the appropriate audiences?
- Were training modules and materials helpful?
- Were trainers competent and committed?
- Was implementation support/follow-up provided?
- What do you perceive to be the primary objective of the approach? Was it achieved? Why or why not?

Questions about particular groups (in addition to above general questions, as relevant):

- ***CODESA:***
    - Why had some of these languished (were not performing at Project inception)? Did it make sense to try to revitalize them?
    - What are examples (if any) of their playing an accountability role in regards to health services? How does that play out?
    - How does their referral mandate function, impact effectiveness?
    - Please provide an assessment of the action plans they have created.
    - What are the means by which they have mobilized community resources? Was any coercion involved?
- ***Community Champions***:
    - What is their relationship to CODESA?

- What is the link between their mandate to identify problems and create action plans, and that of CODESA?

Appendix C: References and Key Informants Interviewed

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Key Informants Interviewed

Name	Position and Institution
Ministry of Health/Health Facilities	
Baudouin Kalume Tutu	Director, Family health and Specific Group, Ministry of Public Health (Kinshasa)
Marie-Albert Tshizemba	Provincial Division Chief (*Médecin Chef de Division Provincial de la Santé*), Mwene Ditu, Kasai Oriental
Jean Michel Mutombo Muteba	Medical Chief, Bibanga Zone (*Medecin Chef de Zone*) (+ 3 staff)
Elvis Badianga Kumbu	Medical Chief, Dibindi Zone (+ 2 staff)
Emmanuel Tshibamba	Supervising Nurse, Kanda Kanda Health Zone
Kamuanga Tshijiba	Managing Adminstrator, Bibanga Reference Hospital
Nzeba Ndjibu	Director of Nursing, Bibanga Reference Hospital
Cisuaka Bilenga	Medical Doctor, Bibanga Reference Hospital
Mbuyi Kitenge	Nurse in Charge, Bibanga Health Center (+ 2 staff)
Ngoya Kabangu	Nurse in Charge, Deux Ns (Bufua) Health Center (+ 3 staff)
Ngongo Membe	Nurse in Charge, Sante Jovial (Katshiampanga) Health Center (+ 3 staff)
Jean Paul Tshilengi	Nurse in Charge, Bakwabowa Health Center
Gustave Muramba	Nurse in Charge, Kabuela Health Center (+ 3 staff)
Local Administrators	
Albert Mukadi	Deputy Mayor, Mwene Ditu, Kasai Oriental
NGOs/CSOs	
Josue Nkanisha Tshombe	Deputy Provincial Coordinator, Conseil National des Organisations de la Sante (CNOS)
Rose Noella Mbuyi	Provincial Representative, Societe Civile de Kasai Oriental (SOCIKOR)
8 members	Club des Amis Damien (in support of tuberculosis victims)
Evariste Kayemba Lukusa	Coordinator, Reseau des Associations Conviviales des Jeunes (RACOJ) (+ 15 members/survey staff)
Emmanuel Nyimba	Coordinator, Actions Pour Developpement Integral Durable (ADID) (+ 7 members/survey staff)
Community Groups	
7 members	CODESA, Bibanga Health Center
6 members	CODESA, Deux Ns (Bufua) Health Center
10 members	CODESA, Sante Jovial (Katshiampanga) Health Center
12 members	CODESA, Bakwabowa Health Center
10 members	CODESA, Kabuela Health Center
Alphonse Mpiana	President, CODESA, Reference Health Center
Crispin Kankwenda	President, CODESA, ASCHP Health Center
Charles Kadima	President, CODESA, Kasai Medical Health Center
Celestin Tshilambu	President, CODESA, La Vie Health Center
--	President, Champion Community,3 Sub-Zones including Bakwabowa and Kabuela, Kanda Kanda Health Zone (+ 15

	members)
USAID/Other Donors	
Jodi Charles	Activity Manager, Health Systems Strengthening
Reena Shukla	Agreement Officer Representative, LMG Project, Office of Population and Reproductive Health (PRH)
Ken Sklaw	Technical Advisor, HIV/AIDS Office
Izetta Minko-Moreau	Health Team Leader, USAID, Kinshasa
Richard Matendo	IHP Agreement Officer Representative, USAID, Kinshasa
Godefroid Mayala	Health Systems Strengthening and Family Planning Specialist, USAID Kinshasa
Sarah Keener	Principal Social Development Specialist, World Bank, DC
Lauren Kelly	Evaluations Specialist, Internal Evaluation Group, World Bank, DC
Hadia Samaha	Health Specialist, Africa Region, World Bank, DC
IHP Staff Kinshasa	
Ousmane Faye	Project Director (Chief of Party)
Delmond Kyanza	Technical Manager Health Finance, Results Based Financing Unit
Jean-Baptiste Mputu	Behavior Change Communications Technical Advisor
LandrySerges Malaba	Communications Advisor
Rood Merveille	Director for Country Operations/ Finance and Administrative Specialist
Lucy Zikudieka	Senior Technical Advisor, Maternal and Newborn Health
Patricia Ndagano	Senior Program Assistant
IHP Staff Kasai Oriental	
Didace Demba	Senior Technical Advisor/Provincial Representative, Mbuji Mayi
Emmanuel Mulunda	Senior Technical Advisor/IHP Field Director (acting), Mwene Ditu
Jean Claude Lubamba	Technical Associate/WASH, Mwene Ditu
Jean Pierre Bianga	Monitoring and Evaluation Specialist, Mwene Ditu
MSH & IHP Staff & Subcontractors	
Kristin Cooney	Director, Country Portfolio, Health Programs Group (HPG)
Joan Marshall-Missiye	Senior Project Officer, HPG
Carol Douglas	Communications Officer, HPG
Sarah Ranney	Project Associate, HPG
Reshma Trasi	Monitoring, Evaluation and Research Director, Leadership, Management and Governance (LMG) Project, HPG
Megan Kearns	Deputy Director, Leadership, Management and Governance Project, HPG
Lora Wentzel	Senior Project Officer, HPG
Meghan Guida	M & E Specialist, HPG
Lynn Lawry	Senior Director of Research and Evaluation, Overseas Strategic Consulting Ltd (OSC)

Appendix D: Notes on Discussions with CODESAs and Health Center Staff: Bibanga, Kanda, and Dibindi Health Zones October 15-20, 2015

Health Center (HC)	**Bibanga ***	**Maternité des Deux- Ns ***	**Katshiampanga ***	**Bakwabowa ****	**Kabuela ****	**Dibindi Health Zone** 4 health centers
CODESA members						
Number attending meeting and their profile	7 (2 women); have been members 4-8 years.	6, all men (CODESA does include women but they could not attend.) RCs for 2-7 years.	10 attended, of which 2 were women (20 members in all). Most are farmers. RCs since 1994-2015 — many for quite a long time. CODESA president not there, but VP was.	8 CC + 5 CODESA + 7 who are members of both (20 in all). (Total CC membership = 24). Over half have been RCs at least 5 years and several 10 years or more. teacher (1), ministers (3), farmers (9) traders (3). One is president of an assoc. of mothers.	10, of which most there at least 5 yr. Farmers (5 incl President), teachers (3), "community leader" (1), community nurse (1). CC also works in this subzone (as well as a third subzone along with Bakwabowa)	4 CODESA presidents in joint meeting held at Mwene Ditu HZ hdqtrs. profile: civil servant, primary teacher, business person/trader (commercant), other. (one of the CODESA presidents—not present at this mtg—is a woman.
Why are you an RC (relais communautaire)?	Wanted to help their fellow community members.	To contribute to the development of our community, our health center To help the community of our area health To play the role of bridge between the community and the health center	To help the community of our area health To transport patients to health center To guide the patients to the health center To sensitize the community good practices	Very active and passionate about their work	Rather reticent	Want to help fellow community members
How were you selected?	Elected. Several candidates.	Elected	No real sense of election	Elected by community through the cac process according to	3 were elected, 3 seem to have just volunteered themselves.	--

				established criteria		
How many hours do you devote to RC work?	Up to 4 hr a week.	1+ hr per demonstration (often several per week) plus planning mtg in CODESA	1-4 hr per week, do something almost every week		Average 6 hr per week + 2-3 hours on CODESA work and 2 hr CAC work per week	Devote considerable time, as the also reach out to TB patients
What is your role as RC?	Provide information to improve lives. Mobilize physical resources of the community. Try to get people who don't want to go to HC to change their minds.	Info to community and community to HC. Latter is mainly to report someone who is sick and can't get there. Or for consultations *pré-scolaires*. Raise resources in the community. Deliver key messages. Home visits. Nutritional demonstrations. Participate in CAC	To link the community and the HC. Sensitization, transport to HC. Community needs training on health concerns. Most important areas to transmit messages: malaria, child nutrition, pregnant women, vaccination. Family planning. Mgt of springs.	Counsel community members: use of latrines. Mothers give birth at centers. Use mosquito nets.	Be the bridge between hc and population. Help people. Give info back to HC. Encourage mothers to give birth at hc, birth spacing, vaccination calendar. Bring sick people to HC.	Messages, spokespersons for community, reference role
Are you spokesmen (arms) of the HC or arms of the community.	Both. People have right to give feedback. We are reps of the community	Both. Carry information in both directions.		All believed that they are more arms of the community than of the HC.		A bridge between HC or govt structures and population, speak in name of community
Your CODESA activities	Try to arrange for people who can't afford the fee to pay on credit over time. CODESA meets the 3rd day of each month. Discuss indicators, give feedback to HC. Several people ran to be President.	Have a field and a little livestock to raise money to help poor people. Will decide in CODESA how to use it. Help with establishment and operation of CACs.	Have a field but have had it a long time. RCs themselves work the land. Would like to add other crops. Revenues of 106,000 Fr in a savings account but no specific plans for use, and no one seems to know how it would be decided how they'd be used.	Distributed family kits furnished by UNICEF.	Discuss budget of fees. 30% for drugs, 5% for investment, the rest for the personnel.	Target future visits. Discuss indicators. Stimulate weaker RCs to improve their performance. Have occasionally negotiated with service providers to drop payment requirement for really poor people.
Does your CODESA have an action plan?		Yes. Focuses on indicators, mobilizing community resources and our own work			Seems to be what the RCs do at the HC—their work	Yes, all have action plan for upcoming month.

		(field). Will decide within CODESA how to spend profits.				
SAcc role of CODESA		participate in mgt and dvlp of the HC.		Checks out meds when received at Bureau Central and at HC. Can look at budget and revenues. Speaks up to HC staff.	Checks out arrival of meds. CODESA president aware of development committee	Feel we play that role but have good relations with HC staff whether in public or private center (although private HCs can do somewhat what they want).
Why don't people go to HCs?	Poverty, distance of HC, lack transport and communications	Cost	Cost	Cost	High cost	High costs
What are the community's major complaints?	Cost (fees) Staff aren't always there	Fees	People don't seem to have many complaints. Space is too small. Not enough beds. HC land is rented, so can't really effect capital changes.		Fees	
What has project brought?	RBF has allowed reduction in fees, sick people now come. Orig fees: ? new fees?	Fees: For children: were 3000, now 2500 For adults: 4,500-5000, now 3500. Many more people now coming to HC — from 15% to 40% use rate. Price of drugs reduced.	Reduction in fees. Children: from 3000 to 2000 Adults: from 7000 to 4000. Have heard of FBR. Improvement in care. Greater transparency of mgt. Specific inputs: delivery tables, scales, mosquito nets.	IHP complemented by HPP (family kits)in 3 health zones, furnished by UNICEF). Also MSH Pathfinder Evidence to Action project. Did not have RBF under IHP but these projects substituted for it in encouraging change. Has motivated RCs to be more dynamic. Fees: Child from 3000 to 1000 Prenatal consultation: 1000 Birth delivery: 1000	Const. rehab HC (with help from community; RCs contributed cement. Family kits (UNICEF). Acts as subsidy to health system. Subsidies to CODESA mtgs. Fees: children 1000 per qtr. (can go as many times as needed during that qtr.); adults 5000 (Depends on illness). Had not heard of RBF, but had some idea after being briefed. 20% of RBF went to community to create	financed monthly meetings plus other activities of CODESA. Greater use of mosquito nets, hand washing, use of breastfeeding, respect vaccination calendar , births at HC. Fees: birth: 3000 consultation child 2500 consultation adult 3500. really feel a partnership with the HC,

				Other adult fees: vary by illness	community field. Hope that it generates revenues that can be used after project ends to substitute for what project has provided.	
What changes have you seen in community?	Wash with clean water and diff to sleep under mosquito net Birth in health center	More people come to HC for health and births. Wash with clean water and diff. basins (clean water each time) for all family members. FP messages and birth spacing. 2-3 yr. Vaccination calendar better respected.		Births at HC. HHs have latrines People use mosquito nets. Use different methods of FP. Fewer incidences of sick people staying at home instead of going to HC. Populations built holes for trash. Death rate down. Anemia and maternal deaths down.	More attendance as fees have dropped.	See above. Raising consciousness of pop.
Traditional healers	Bad fate	People still go because no money for HC	Go not only due to absence of funds but also for certain diseases.		Go for cultural reasons mainly — sometimes traditional healer is more expensive	Depends on sickness, but usually due to poverty or lack of information. Also go to Chinese healers.
Other observations		Can broach the topic of family planning just after mothers give birth, then follow up in community.	Have heard of RBF and OAC; may not be too clear about it, but know FBR has brought good things.	Very dynamic RCs and CC. Performed a little skit about counseling new mothers. Hope to continue after project. CODESA President received 3 days training in drug verification and 3 days in data analysis.		Believe we will be able to sustain the efforts of the program.
Citizen feedback survey			Don't really know. Had heard of OAC.	Not really aware but HC has a suggestion		

				box and even undertook a survey—results showed need for improvement in attitudes of personnel and delays in treating people (info provided by HC staff, not CODESA).		
Health Center personnel (numbers indicate those who attended)	*infirmier titulaire* and birth attendant.	Infirmier titulaire (proprietor of HC), 2 accountants (?), receptionist	Infirmier responsible, birth attendant, receptionist	Infirmier traitant+ 2 others. + a doctor working at HC while we were there. Infirmier superviseur from Zone Sanitaire also present (representing HZ).	Infirmier titulaire, lab tech, administrator, attending nurse (also have another nurse and a birth attendant, not at mtg; 11 staff in all)	(Did not meet with Dibindi HC staff, as meeting was held at HZ hdqtrs with 4 CODESA presidents)
		3 out of 5 receive govt pay.	None receives any pay. All paid from fees.	2 (doctor and one aide) receive primes 2 do not	2 out of 11 receive prime (1 nurse and the birth attendant)	
Role of CODESA	Their comments included in above comments of CODESA members	Creates a bridge between HC and community; refers people to HC, sensitizes people to what HC can offer, follows up on cases, assists cases where people lack funds, work with CACs. Believe CODESA members do speak up. CODESA is effective despite differences in dynamics of different RCs.	Feels there's a real collaboration with CODESA, helped construct a wall (CODESA members themselves built it). Meet once a month. Think RC reference work is good.	CODESA knows what the balance is in the HC cash situation (dans la caisse). Has a Development Committee with 6-8 people nominated by CAC among the RCs. They play a social accountability role.	CODESA members helped to build expansion to HC—seem timid but some members are quite dynamic. CODESA action plan is a plan for the members (RCs) themselves, not so much for the community. RCs play good referral role. More dynamic RCs influence the less dynamic ones—seems to motivate them.	
Changes in community since project		Now more demanding. Negotiated fees. Funds are used for operations,	FBR allowed repairs, painting HC, shower for mothers. FOSACOF	Health indicators up significantly: latrine use from 34% to 89%;	Reduction in mortality: used to be 1-2 maternal deaths	

		maintenance and prime to the personnel. 100% of births now take place at HC. Rate for curative care gone from 15-18% to 30-40%. Community built bamboo wall around HC. Would like to build some wells but need funds.	allows them to respond to weak points.	mosquito net use: 21% to 63%, assisted births from 20 to 36 per month.	quarterly, now none. Increase in births at HC has risen from 20% to 90%.	
Other innovations		Have a journal of income and payments. Give a small incentive payment to RCs — soap, meal etc. They receive $15 for coming to monitoring mtg.	Give them a small incentive payment; some are more dynamic than others. But incentive has helped. Reduced fees due to provision of drugs plus competition with nearby hospital which charges lower fees. Fees were negotiated in dialogue with CODESA.	Under HPP 20% of their financing is to subsidize community activities. Have been able to subsidize caesarians. Don't know about client survey but have a suggestion box. And sometimes do a mini-survey.		
Suggestions for improvements/other observations		Too long for drug deliveries; supposed to be 3 months but is sometimes longer. FBR: amount is insufficient. Would like more training. Nurse-owner does not hesitate to ask for more! But is apparently one of the best-run HCs		Financial barriers will re-emerge as project draws to a close, especially without drugs. No receptionist because of cost constraints.	CUG not functioning for various reasons. Constraints: lack of payment (a woman who gave birth by caesarian 3 wk. ago is still being held at HC because she hasn't yet paid her fees.	

:* : Health centers located in Bibanga Health Zone
** Health centers located in Kanda Kanda Health Zone

Notes: These notes were prepared by the author as an informal means of organizing interview notes and is not intended as a formal document.
Abbreviations: CAC: Cellule d'Animation Communuataire CC: Champion Community dvlp: development HC: Health Center hdqtr: headquarters HPP: Health for the Poorest Populations Project. HZ: Health Zone (Zone Sanitaire) mgt: management OAC: Organisation d'Assises Communataires RC: Relais communautaire SAcc: social accountability (redevabilite)