Summary Information

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DRC
Funding Request Malaria
Program Continuation

Allocation Period 2023-2025

March 2023

Country(s)	**The Democratic Republic of the Congo**
Component(s)	**Malaria**
Planned grant start date(s)	01 January 2024
Planned grant end date(s)	December 31, 2026
Principal Recipient(s)	Ministry of Health PR Civil society: Bidding process in progress
Currency	USD
Allocation Funding Request Amount	**US$ 377,027,254.36**
Prioritized Above Allocation Request (PAAR) Amount	**US$ 129,585,702**
Matching Funds Request Amount (if applicable)	n/a

Refer to the Program Continuation Instructions for the detailed elements related to each question which should be addressed for a response to be considered complete. The Instructions also include information, resources and a description of necessary documents to be submitted along with this form.

1 # Section 1. Prioritized Request

Module 01	Vector Control ☒ Renewal
Intervention: 1	**Distribution of LLINs** ☒ Renewal The LLINs will be acquired through the same channel as NFM3 and will be transported to the local level where distribution will take place. The estimated total LLINs to be distributed is 122,206,874 in three years. These LLINs will be distributed through several channels. **a. Digital Mass Campaign - Universal.** A total of 93,221,253 LLINs will be distributed to a population of 159,807,862 people during the GC7 grant, all of which will be acquired with funding from AMF (based on enumeration data and double counting the five provinces that will have two campaigns in the same cycle). **The Global Fund will cover international logistics and operational costs at the country level for 71,580,332 LLINs to households in 20 provinces (3 of which with two campaigns during the cycle) while PMI will cover 21,640,921 LLINs to households in 6 provinces (2 of which with two campaigns during the cycle).** Taking into account the dynamics of the extension of resistance and the history of implementation, the country opted to retain LLIN PBO (19) provinces) and double-treated LLINs (7 provinces). LLINs are estimated to last 2 years (Annex 1: LLIN Sustainability Study) leading the country to reduce the frequency of campaigns every 27 months (24 to 30 months) on average to take into account the sustainability of LLINs. However, efforts will be made to improve the sustainability of on-the-ground LLINs through actions promoting care and repair of LLINs. ***This explains why only 5 out of 26 provinces benefit from more than one pass during the grant***. **b. Continuous distribution - Antenatal consultations.** As with mass campaigns, the same types of LLINs will be used in the same provinces: LLIN PBO 19 Provinces and Dual-Processed LLIN in seven provinces. A LLIN will be distributed to all women attending their first prenatal visit. A total of 17,054,542 pregnant women are expected to attend the antenatal consultation during the period 2024-2026, including 9,758,637 in the 16 provinces of Global Fund intervention plus Kasai. **c. Continued distribution - Expanded Program of Immunization (SMC/ENP).** As for prenatal consultation, 19 provinces will use PBO LLINs and 7 provinces will use Bi-treated LLINs. Every child who comes to the preschool consultation will receive a net, which represents a national need for 14,880,088 LLINs over the intervention period, including 634,386 in the 17 provinces of intervention of the Global Fund.

	d. Follow-up Post Mass Campaign Independent monitoring per- and immediate post-campaign is systematically organized by WHO or another organization. In addition, the Independent Post-Distribution Monitoring (PDM) system is already in place and funded by AMF will continue at 9 months, 18 months and 27 months after distribution and will focus on the coverage, use, durability and effectiveness of LLINs.
List of activities	***Continuation and intensification: See NFM3 funding request*** (1) Develop macro-plans annually for campaigns; (2) Update the routine LLIN supply plan annually; (3) Purchase LLINs (4) Ensure transport to the health zone level; (5) Strengthen the capacity of campaign implementers; (6) Organize distribution of LLINs to all women going to their first prenatal visit; (7) Organize distribution of LLINs to infants during immunization activities; (8) Organize distribution of LLINs to households; (9) Ensure independent per and immediate post-distribution monitoring; (10) Organize validation of distribution data mass and routine; (11) Monitor coverage, use, durability and effectiveness of LLINs
Priority populations	- Pregnant women - Routine distribution under the antenatal consultation - Children under 5 - Routine distribution under the expanded programme of immunization - Key Populations / Vulnerable Pops: (Landlocked populations, displaced populations, refugees, etc.): Key populations as well as vulnerable populations will also benefit from distribution through antenatal consultation services in fixed and advanced strategies and community distribution. Finally, it will be used: expanded programme of immunization services in fixed and advanced strategies, ad hoc vaccination campaigns. - General population
Key and Landlocked Populations	Historically, mass distribution activities have been carried out taking into account the specific needs of the most vulnerable populations such as ***IDPs and refugees*** (this was the case during distributions in Ituri province where IDP camps conducted counts) and ***the victims of disasters***; it is to this end that in 2018, ***climate-displaced people from the Sahel*** in Bas-Uele and Haut-Uele provinces benefited from the LLIN after counts. The micro-planning of campaigns takes into account ***the gender aspect*** by setting at least one third (***in line with the DRC Constitution which requires a minimum 30% quota reserved for women in all sectors***) the number of women among the RECOs who are engaged in household counting and distribution activities of the LLINs and by involving ***women***'s ***associations*** in social mobilization. The transition from fixed site distribution to door-to-door distribution following COVID19, during NFM3, was an opportunity to ensure the deployment of LLINs ***to households including those most landlocked***. (Annex: Adapted approach at sub-national level (i.e. type of LLIN, blankets, rural context (urban life, gender, age, level of education, etc.) HIV key populations (SW, MSM, TG, IDU) will benefit from distribution through their user-friendly centers (Indeed, the majority of HIV key populations do not live in traditional households and this was noted during the community dialog where they wanted to integrate malaria services into user-friendly centers. Specific sites of key HIV populations have been found to benefit from the LLIN mass distribution campaign, sometimes seeing them used for other purposes by tenants).

<table>
<tr>
<td>Amount requested</td>
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<table>
<tr><td>LLIN mass distribution campaign</td><td>$114,629,040</td><td>Operational costs.
LLIN purchases covered by AMF</td></tr>
<tr><td>LLIN Routine</td><td>$50,723,467</td><td>LLIN Purchase & Operational Costs</td></tr>
<tr><td>TOTAL AMOUNT</td><td colspan="2">US$165,352,507</td></tr>
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<tr>
<td>Expected outcome</td>
<td>
En simulant l'impact de l'intensification des deux principales interventions (MILD et traitement), nous constatons que l'augmentation de la couverture des MILD est un facteur important pour empêcher l'augmentation de l'incidence
Clinical cases per year (millions)
Continuer la couverture de MILD et la couverture de traitement aux niveaux de 2019
Augmentez la couverture des MILD à 65% et la couverture du traitement à 60%
Augmentez la couverture des MILD à 75% et la couverture du traitement à 60%
2020: –; 2021: 33 m / 29 m / 25 m; 2022: 35 m / 29 m / 23 m; 2023: 38 m / 31 m / 24 m; 2024: 40 m / 33 m / 26 m; 2025: 42 m / 36 m / 29 m; 2026: 44 m / 38 m / 31 m
Remarques: la couverture en MILD 2019 est en moyenne de 61% (fourchette: 28% -79%), la couverture de traitement est de 14% (fourchette: 4% -25%) Nous supposons une croissance démographique de 3% chaque année, ce qui explique l'augmentation de l'incidence sans augmentation d'échelle (inclut également les effets de l'immunité)
Figure 1. The impact of predicting increased LLIN coverage and access to treatment.

• Increase in LLIN household coverage (1 LLIN per 2 persons) from 26% (MICS2018) to 60% by 2026.
• Increase in the adequate use of LLINs in the general population from 48.4% (MICS2018) to 80% by 2026.
• Increased use of LLINs in pregnant women from 52.4% (MICS2018) to 80% by 2026.
• Increase in the use of LLINs in children under 5 years of age from 51% (MICS2018) to 80% by 2026.
Reduction of morbidity: with increased LLIN coverage, there will be a reduction in cases that will be reversed during the implementation of the GC7 with the combination of efforts to extend coverage of the case management to the private sector and the community (Fig1).
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Specify how the accuracy and reliability of the reported results will be ensured	Since 2006, the DRC has been distributing LLINs free of charge both during campaigns and routine distributions. The experience of '*door-to-door distribution'* has led to a better understanding of the targets and more adequate training of the agents responsible for this activity. With the introduction of digitization of campaign management over the past cycle, data quality has improved significantly. In addition, 5% monitoring by a CSO platform is an important citizen monitoring mechanism to verify the effectiveness of reaching all final beneficiaries. The DHIS2 has improved year on year with improved health pyramid configuration to improve completeness, breach rules to detect inconsistencies for correction, and RDQA missions to improve data quality. This device makes it possible to provide quality indicators relating to routine interventions.
Intervention 2	**Communication** ☒ Renewal To ensure the ownership and use of the LLINs distributed through all these channels and the community's adherence to the various VC strategies. Communication activities will be carried out with an emphasis on effective community involvement throughout the process from planning to implementation and monitoring of the effectiveness of activities.
List of activities	(1) Strengthen the capacities of health workers and RECOS in SBCC in support of vector control (VC) interventions; (2) Organize pre-, per- and post-campaign (LLIN) communication; (3) Organize home visits to raise awareness on the hooking up, repair and effective use of LLINs to optimize the sustainability of LLINs coupled with community renewal of LLINs to help maintain coverage between campaigns; (4) Strengthen community leadership for their effective participation in decision-making on the implementation and monitoring of the effectiveness and compliance of the results of VC interventions; (5) Involve CSOs and civil society actors in planning meetings/workshops at all levels (CAC, Health Area, Health Zone, Provincial Health Division, central level); (6) Organize community monitoring of the implementation of interventions like 5% monitoring; (7) Organize post-campaign monitoring through primary school pupils.
Amount requested	VC Specific Communication - $5,927,922.43
Expected outcome	More than 50% increase in the quality verification rate for LLIN 50% increase in LLIN hanging rate at sleeping areas
Specify how the accuracy and reliability of the reported results will be ensured	Since 2006, the DRC has been distributing LLINs free of charge both during campaigns and routine distributions. The experience of '*door-to-door distribution'* has led to a better understanding of the targets and more adequate training of the agents responsible for this activity. With the introduction of digitization of campaign management over the past cycle, data quality has improved significantly. In addition, 5% monitoring by a CSO platform is an important citizen monitoring mechanism to verify the effectiveness of reaching all final beneficiaries. The DHIS2 has improved year on year with improved health pyramid configuration to improve completeness, breach rules to detect inconsistencies for correction, and RDQA missions to improve data quality. This device makes it possible to provide quality indicators relating to routine interventions.

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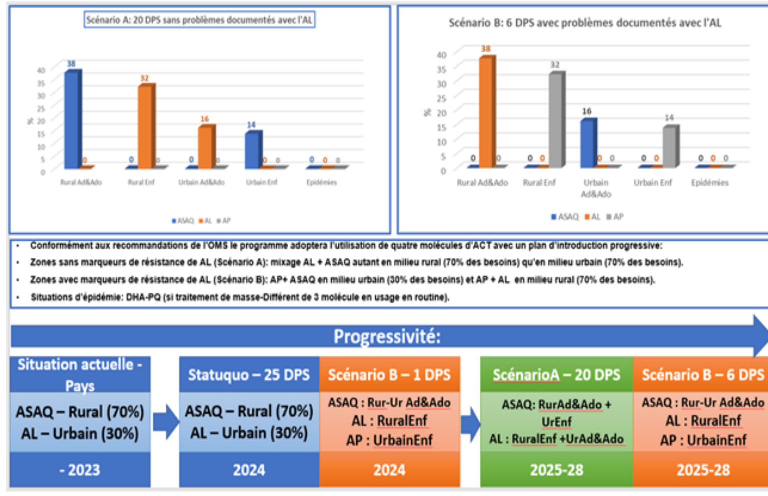
Module 02	Case management ☒ Renewal

Intervention 1

The management of malaria cases will be carried out in the public sector, from the private sector to the community level, taking into account the experience gained during the current grant (NFM3). The new grant will test a total of **85,776,574** suspected cases over three years. These suspected cases will benefit from biological confirmation that will gradually increase (94% in 2024, 97% in 2025 and 100% in 2026). A total of **58,865,344** confirmed cases can be treated with ACT over 3 years.

Case Management of cases at the level of Public Health Training.
The estimated total suspected cases of malaria in the public sector are **71,980,460** over 3 years. The program will continue to support malaria treatment in the Global Fund's 16 provinces of operation (322 health zones) plus Provincial Health Division Kasai, which has benefited from Global Fund antimalarial drugs since the NFM2 grant. A supply of supporting inputs will be provided, in particular to ACT in line with national policy: AL, ASAQ. In line with WHO recommendations, the program will adopt the use of four ACT molecules with a phase-in plan. In areas with markers of resistance to AL, AP and ASAQ will be introduced in urban areas, representing 30% of the needs. In rural areas, AP and AL will meet 70% of the needs. In areas where no markers of AL resistance have been found, AL will be introduced for rural children's case management, 32% of the need. DHA-PQ will be used primarily for epidemic response.



<table>
<tr><td></td><td>Management of severe malaria
This will involve making available Artesunate Injectable at the level of reference structures with hospitalization capacity; quantification is limited to the estimated needs of children under 14 years of age under GC7. The age group over 14 will be insured by the Governmental counterpart. Rectal artesunate for health centers (first level, including in pre-transfer situation) to ensure referral of severe cases

To improve the availability of quality medicines, laboratory reagents and inputs for malaria control, the NMCP will establish mechanisms for the safety of antimalarial medicines and inputs, as well as mechanisms for monitoring and evaluating the availability and use of antimalarial medicines and inputs (EUV). A framework for policy dialog will be established to strengthen regulations on the licensing of anti-malarial drugs (DPM).

Continuing with the current grant, the NMCP will continue to strengthen and coordinate procurement activities (PIM). Supply plans for antimalarial drugs will be harmonized with the various partners. The working groups (case managements, PIM) will be organized.
In order to deliver the most appropriate treatments, the NMCP will update and disseminate malaria control standards and guidelines (malaria control) every 3 years with the production of training modules for cascading training/retraining of providers, followed by post-training supervision</td></tr>
<tr><td>List of activities</td><td>Continuation and intensification: See NFM3 funding request
- Making available quality inputs of malaria control: medicines, laboratory reagents and equipment for case management
- Perform biological confirmation of malaria cases (RTD, microscopy) and Administer treatment for confirmed malaria cases;
- Strengthen supply coordination activities (PIM).
- Strengthen the capacity of laboratory providers and Health Zone Executive Team on new national guidelines, biological diagnosis and quality assurance (QA) for malaria;
- Strengthen the capacity of and oversee managers of Provincial Health Division, Zone Executive Team and SSE providers in malaria management</td></tr>
<tr><td>Amount requested</td><td>ACT and RDT - US$78,746,217.49</td></tr>
<tr><td>Expected outcome</td><td>• At least 94% of suspected malaria cases receive parasitological testing
• 100% of confirmed malaria cases receive adequate antimalarial treatment at all levels including community level</td></tr>
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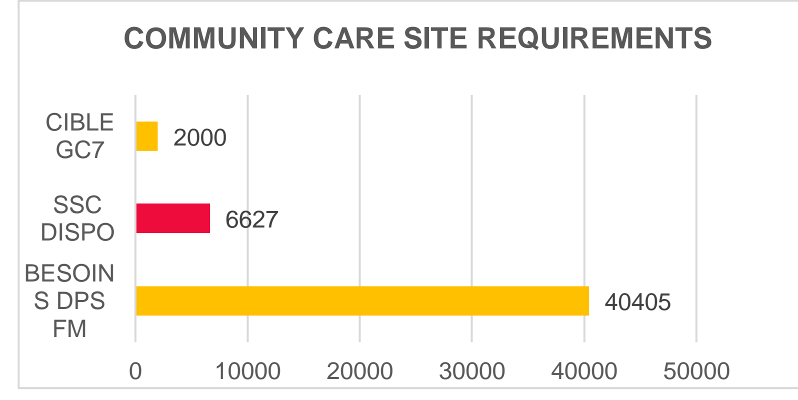
Intervention 2	**Integrated case management at community level (PEC-C).** The number of operational community care sites is 10,112 (6,627 for GF support areas, 3,461 for PMI and 24 for KASAI Provincial Health Division) at the end of 2022 out of a national requirement of 65,586 (source community health strategic plan). In the 16 provinces supported by the Global Fund, 6,627 community care sites are located on a need of 40,405 community care sites, a coverage rate of 16.4%. Given the significant gap, DRC plans to increase the number of community-based care sites from 2000 for GC7's 3 years to increase coverage from 16% to 21% by the end of 2026. In 2022, 2,589,545 people were tested, and a total of 1,916,835 were treated, with a positivity rate of around 74%. At the community care site level, case management for simple cases and pre-referral treatment will continue and be extended to all new community care sites. 9,138,885 of the suspected cases will be tested and 6,466,868 positive cases will be treated in accordance with national policy; particular emphasis will be placed on the quality of care in community care sites  In order to expand the services provided at community level, in addition to community care site coverage, the following have been selected: (1) Provide the supplementary package (Diarrhea and acute respiratory infections case management) in accordance with the community care site Implementation Guide. (2) Maintain and expand ReCosite's home treatment strategy - *implemented in the context of COVID 19* - with two visits per month. Initial data showed that over 30% of treated cases originated from home visits. (3) Enhance the quality of supervision through (a) digitalization of supervision at the level of each community care site - which will allow for better visibility on low-performance community care sites, (b) strengthening of central and provincial-level formative supervision targeted in low-performance areas, (c) holding collaborative learning sessions between Recosites and then between ITs, on already existing exchange platforms.

List of activities	***Continuation and intensification: See NFM3 funding application."*** • Train 4,000 ReCosites of the new sites on the entire grant (2 RECO per site). • Supply all new community care sites with quality small equipment, and replenish missing/non-operational equipment for existing community care sites. • Provide all community care sites with tools for monitoring support; • Provide training on tools for ReCosites and ITs that have not yet been trained on them (8% of former sites). • Provide community care sites with testing (RDTs), management inputs (malaria, diarrhea and acute respiratory infections), paracetamol. • Ensuring the digitalization of community care sites supervision • Providing home treatment through RECOSITE mobile requires two monthly visits. • Provide monthly IT supervision and quarterly supervision at the provincial and national levels.
Amount requested	ACT, RDT and community activities - $33,251,458
Expected outcome	2,000 community care sites in 16 Provincial Health Divisions supported by the Global Fund, 80% of community care sites have the complete package of interventions, 100% of suspected cases of malaria tested at Community level, 100% of malaria cases treated, 80% of acute respiratory infections cases and diarrhea treated at Community level
Intervention 3	❖ **Expanding support in the private sector**: Nearly half of the DRC's population relies on the Private Sector, which does not follow the NMCP guidelines, does not report data and costs money. Of the 55.3% of children under the age of 5 who are febrile and are seeking care, 46.8% are in the private medical sector, of which 28.2% go to pharmacies and 6.7% to hospitals/practices and 11.9% to the non-medical private sector. (NSP NMCP 2020-2023; DHS 2014). The private sector provides more than 70% of the antimalarial drugs circulating in the DRC. These products are in the informal private sector and quality is not always guaranteed. To ensure equitable access to quality medicines, the NFM3 grant covers 7 cities in the 16 Provincial Health Divisions supported by the Global Fund (50 Health Zones, 70% of which are in Kinshasa, 16.2 million inhabitants). It has improved access to RDTs for routine diagnosis of fever). RDTs have been introduced in 1,113 lucrative health facilities and 305 pharmacies and have been integrated into the DHIS2_Private sector, 5,076 people have been trained, more than 2,000 supervisors have been carried out to improve the capacities of providers and 1,800,000 tested cases (Global Fund PUDR). The NFM3 grant brought to the market 8 million quality ACT (green leaf, fv) or 12% of the market share, at $1.5 bringing a financial gain "*value for money*" of $16,000,000 to the population. This quality ACT is found in almost 75% of

	pharmacies. This low cost of ACT contributed to a decrease in other non-green leaf ACT from $7.5 to $3.5. (Mystery Shoppers 2022) Taking note of the achievements of the implementation of the private sector project NFM3 and considering the current legislation in the DRC that does not allow unqualified providers to perform pre-treatment testing, the NMCP proposes the following adjustments to the GC7: ➢ Testing 1 million suspected cases of malaria annually in the private sector (in 2022, 800,000 cases were tested annually in the private sector); ➢ Treat 100% of positive cases (75% positivity rate) or 750,000 cases per year. The NMCP will continue to advocate at the national level for unqualified providers to be allowed to perform the RDT at points of sale. If this is achieved, the NMCP proposes scaling up by increasing coverage in all private structures in the 7 cities targeted by the project. A forecast amount is therefore included in the PAAR to anticipate this potential change.
List of activities	***Continuation and intensification: See NFM3 funding application."*** - Making RDTs available in 7 current cities - Conduct advocacy for the reduction of taxes and tariffs on health products and services - Continue advocacy for the use of RDTs in all pharmacies registered under the Green Medicines Initiative - Making funds available for ACT copayment - Using medical delegates to promote RDTs and ACT in the Private Sector - Training and supervising private sector providers - Raising community awareness through media and mass activities - Putting in place the tools and further integrating the private sector into the NHIS - Integrate malaria care and promotion of ACT green sheet and RDT (awareness raising, good practices, screening) in youth friendly centers. - Implement a citizen control system for tracking ACT and TDR pricing and availability
Amount requested	**ACT, TDR and activities - $4,704,592**
Expected outcome	• At least 94% of suspected malaria cases receive parasitological testing • 100% of confirmed malaria cases receive adequate antimalarial treatment in the private sector.
Specify how the accuracy and reliability of the reported results will be ensured	The accuracy and reliability of the reported results are based on data traceability, the integration of data from private sector structures into DHIS 2, the quality and clarity of the reporting tools, the data source and the support from the central, intermediate level to the implementing actors.

Intervention 4	**Communication for social and behavioral change** 50% of the population do not seek early care for fever (as do children under 5), and less than half perceive ACT as effective treatments for malaria. These factors negatively influence malaria management in the DRC. https://malariabehaviorsurvey.org/countries/democratic-republic-of-the-congo/?lang=fr . The need to strengthen community involvement in this process, the importance of developing the IPC even at the level of the healthcare provider, the impact of traditional and religious authorities on the population (https://pubmed.ncbi.nlm.nih.gov/34462413/) , the penetration rate in cell coverage (52.1%) and the Internet (26.35%) (https://acpcongo.com/index.php/2022/10/18/) as well as the need for a strategy combining radio, television and mobile technology to reach 70% of the population are the leitmos of this demand to reduce malaria mortality. https://malariabehaviorsurvey.org/countries/democratic-republic-of-the-congo/?lang=fr). Emphasis on the involvement of political and administrative authorities in the project implementation process through the implementation of pleas and accountability sessions for zero-rating and combating the illicit sale of anti-malarial drugs, as well as the application of criminal and administrative sanctions against offenders. (13,14) As the private sector is highly competitive, the application of sales marketing techniques (including street marketing, the use of social media, ambassadors to raise awareness, medical delegates) is one of the conditions for aligning private health facilities and pharmacies with the national malaria management policy. These different strategies will require updating, producing/replicating and disseminating training modules, communication materials, malaria control standards monitoring manuals and guidelines at all levels. Users of these different tools will be trained and supported in their daily use.
List of activities	***Continuation and intensification: See NFM3 funding request*** • Updating, reproducing, shipping and disseminating country-wide tools, training modules, educational materials for both audio and script-visual communication, standards and guidelines for both the public and private sectors • Disseminate tools at the population level, including vulnerable populations, through media, social media and public signage to raise awareness about the importance of RDT for fever and the effectiveness of ACT as a treatment for malaria, free malaria care and combating the illicit sale of malaria inputs; • Organize advocacy and accountability sessions with political and administrative authorities on zero-rating of malaria control inputs, combating the illicit sale of ACT/RDT inputs, and enforcing criminal and administrative sanctions against offenders; • Organize public awareness campaigns on the early demand for fever care and the effectiveness of ACT recommended by the NMCP, and monitor the dissemination of information at all levels. • Ensuring citizen control of the CSO health pyramid
Amount requested	

	Case management-specific communication	$ 373,763	GC7

Expected outcome	• 80% political and religious authorities who were visited during an advocacy visit are involved in the process of tax remission and fight against the sale of anti-malaria inputs in alignment • 80% of the population seek appropriate RDT and care within 24 hours of the onset of fever, especially for children under 5 years of age • At least 80% of private households adhere to the national malaria policy.
Barriers and inequalities	A comprehensive analysis of all barriers, including financial barriers, that may hinder the use of services was undertaken (See Annexes / Vulnerabilities and Key Populations, Analysis Sheet of Obstacles Faced by Key Pops and Results Matching Box ref 15). Barriers were also analyzed by key population groups such as: socio-cultural barriers, barriers related to low availability of health services and geographic barriers. Several strategies have been identified to address these obstacles, including: (1), extensions of the community care sites for a case management at Community level, (2) integration of the private sector into the case management improving access to quality medicines; (3) free allocation of RDTs and ACTs at public level (4) use of communication activities to improve access to care
Priority populations	- All people at risk of malaria - Pregnant **women and children aged 3 to 59 months**
Key and Landlocked Populations	- For **the key and landlocked populations**, the program will involve associations for children in vulnerable situations: (Orphans and vulnerable children: Orphans and Vulnerable Children) for assistance for case management through health centers. All the participants will benefit from a free reinforcement for the care of street children. Association-level focal points will be provided with training and inputs for the care of street children ref 15. Finally, the aid associations will receive financial and technical support to carry out an IEC activity among street children on the availability of services for malaria prevention and management **List of activities** • Train 280 providers of user-friendly centers on the entire grant (2 RECO per site). • Supply 35 User-Friendly Centers with tests (RDTs), treatment inputs (malaria, paracetamol). • Integrate the management and promotion of ACT green leaf and RDT (awareness raising, best practices, screening) in the user-friendly centers of key populations (SW, MSM, TG and IDU):
Specify how the accuracy and reliability of the reported results will be ensured	The accuracy and reliability of the reported results are based on the demonstrated effectiveness of the selected interventions and the fact that they target vulnerable groups and/or key populations as well as the general population. These interventions have a large impact on mortality, which has seen an increase over the two last years after having been on the decline. Coverage of quality malaria control services in health care facilities and in the community is low, in terms of both individual and collective prevention, case management, epidemiological surveillance, epidemic control and tracking of parasite resistance to antimalarials.

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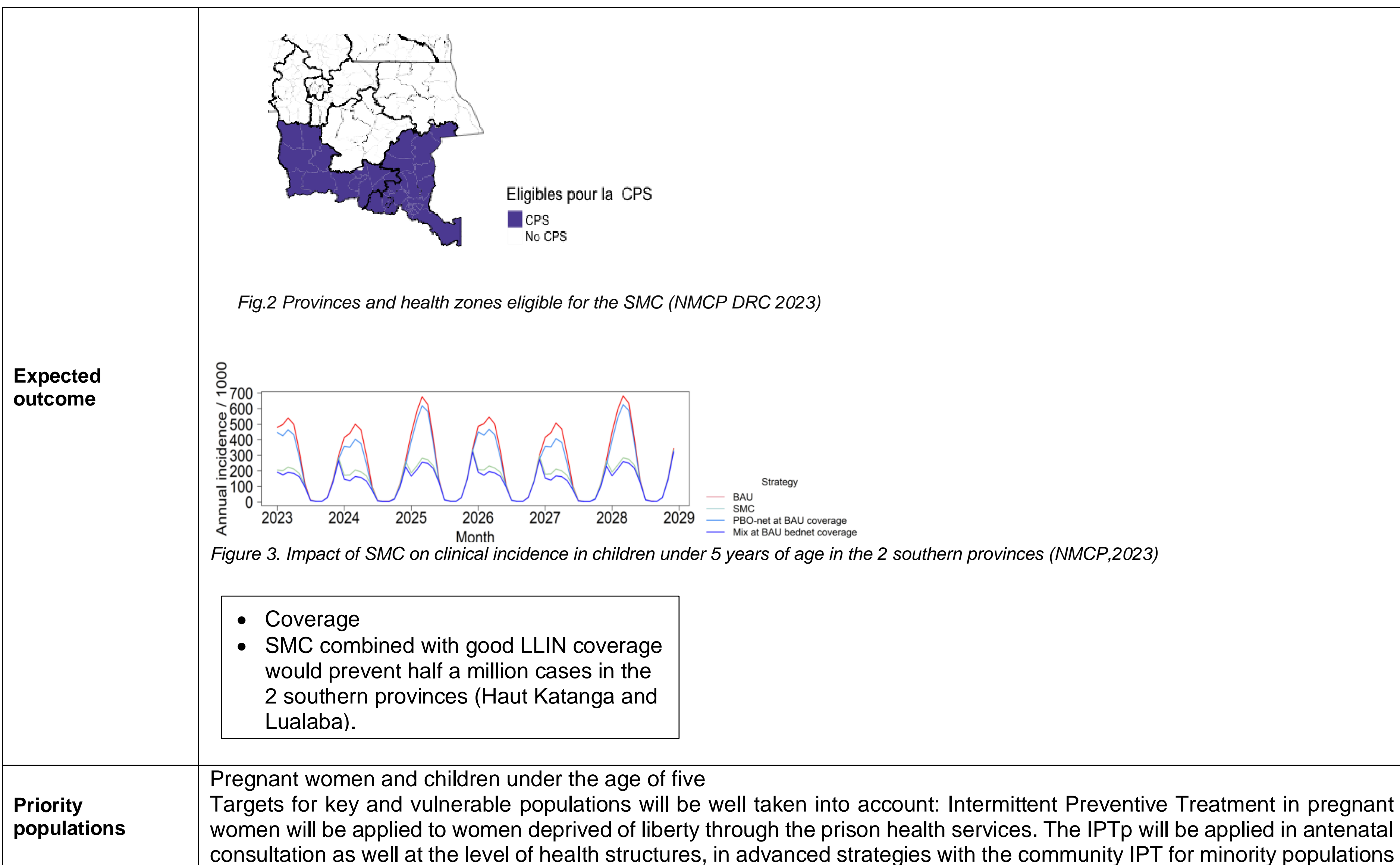
Intervention 1	**Intermittent preventive therapy (IPTp) - Pregnant women**: ☒ Intensification The IPT Coverage Targets over the three years of the GC7 grant are 98%, 81%, 70% and 60% respectively for IPT1, IPT2, IPT3 and IPT4. For these different pregnant women populations expected at these meetings, the MS will be administered under direct observation of the health worker at each of them, the totality of pregnant women seen at each meeting. Innovative community initiatives such as the TIP TOP project are being evaluated and need to be scaled up, given encouraging preliminary results in the Kenge, Bulungu and Kunda Health Zones to increase coverage. Thus, the 10 HBHI Provincial Health Divisions are retained for the scaling up of the Community IPTp during the implementation of GC7, 5 of which are within the Global Fund's scope of intervention. Communication will be intensified to improve the early use of the first consultation among pregnant women and to support RECOS activities in the implementation of the Community IPTp. UHC aims to increase access to the pregnant women antenatal consultation service. This indicator could be integrated into the World Bank project (DFID, USAID and the Global Fund) in order to boost the IPT3 through performance contracting.
List of activities	New activities (1) Update the IPTg implementation guides and tools including the Community component; (2) Build capacity of health workers, RECOs and civil society actors on the Community IPTg; (3) Supply health facilities with SP; (4) Ensure the provision of SP to pregnant women during antenatal consultations: (5) Organize the recovery of pregnant women with late antenatal consultation through home visits by RECOs and civil society actors; (6) Supervise actors at health facility and Community level; (7) Intensify communication to improve early use of antenatal consultation; (8) Integrate the IPT3 indicator into the World Bank for Results-Based Financing project.
Amount requested	**IPTp / Pregnant Women - $7,495,219**
Expected outcome	• Increase in IPT2 coverage from 79% (2022) to 80% (2026) - Source DHIS2; • Increase in IPT3 coverage from 65% (2022) to 70% (2026) - Source DHIS2.
Intervention 2	**Perennial Malaria Chemoprevention (PMC):** ☒ New This assistance will be implemented in the first year of the grant. It was included in the NFM3 but could not be implemented due to insufficient funding. GIVEWELL plans to start this intervention in 4 Health Zones of Kongo Central in 2023. During this grant, this intervention will be implemented in the remaining 27 Health Zones of Kongo Central Province. UNITAID is also interested in creating a pilot in 2 or 3 zones. An extension is envisaged at the end of 2026, if results are conclusive and a decisive impact on morbidity and mortality is demonstrated. Vaccine coverage in Pentavalent and VAR will be taken into account for this purpose. The same applies to geographical accessibility, in order to maximize this intervention's chances of success.

List of activities	New activities (1) Workshop to develop implementation guides and tools; (2) Replicate training tools (standards and guidelines, training modules, fact sheets, communication documents); (3) Build capacity of health and community workers; (4) Organize communication activities for the PMC; (5) Supervise actors at all levels; (6) Organize pharmacovigilance activities; (7) Organize semi-annual data validation workshops; (8) Conduct an impact assessment of the PMC.
Amount requested	**PMC/Infant - $2,248,059**
Expected outcome	397,471 infants receive at least one dose of MS at the SMC, of whom 85% complete the 6-dose schedule in the 27 targeted for Global Fund support to Kongo Central.
Intervention 3	**Seasonal Malaria Chemoprevention (SMC)**: ☒ New This strategy will be implemented from the first year of the grant. It had been included in the NFM3 but could not be implemented due to insufficient funding. It will be implemented during the period defined as high transmission of malaria. Following the revision of the national malaria prevention policy and the stratification achieved in 2022, the eligible health zones are in the 2 southern provinces: Lualaba, and Haut-Katanga, for climatic reasons and observed epidemiological trends. Also for logistical and practical reasons, this innovation will be introduced gradually. We will start with Haut Katanga province (the 11 Health Zones of the city of Lubumbashi). An extension to the other Upper Katanga and 2 urban Lualaba Zones is planned in 2025 and the other Lualaba Health Zone in 2026. The intervention will be financed by the Global Fund and other donors with whom the NMCP is being negotiated (ref16).
List of activities	New activities (1) Organize a workshop to develop guides and tools for implementation; (2) Reproduce training tools (standards and guidelines, training modules, datasheets, communication documents); (3) Strengthen the capacities of health and community workers; (4) Organize communication activities in support of the SMC; (5) Supervise actors at all levels; (6) Organize pharmacovigilance activities; (7) Organize semi-annual data validation workshops; (8) Conduct an SMC impact assessment
Amount requested	**SMC/children - $13,213,002**



Expected outcome	*Fig.2 Provinces and health zones eligible for the SMC (NMCP DRC 2023)* *Figure 3. Impact of SMC on clinical incidence in children under 5 years of age in the 2 southern provinces (NMCP,2023)* • Coverage • SMC combined with good LLIN coverage would prevent half a million cases in the 2 southern provinces (Haut Katanga and Lualaba).
Priority populations	Pregnant women and children under the age of five Targets for key and vulnerable populations will be well taken into account: Intermittent Preventive Treatment in pregnant women will be applied to women deprived of liberty through the prison health services. The IPTp will be applied in antenatal consultation as well at the level of health structures, in advanced strategies with the community IPT for minority populations

	(Pygmies). Concerning the PMC: Intermittent Preventive Treatment in infants, it will be applied if eligible areas. The same is true of the SMC: Seasonal chemoprevention that will be applied at the level of eligible areas
Communication Specific Interventions	Communication Specific Interventions — $ 373,763 — GC7 A particular emphasis of the communication will be placed on the Community IPTp in order to raise the rates of IPT2 and IPT3. The same will be true for supporting the early implementation of SMC and long-term SMC.
Specify how the accuracy and reliability of the reported results will be ensured	As DHIS2 has seen a substantial improvement as a result of improved health pyramid configuration, implementation of violation rules detecting inconsistencies for correction and RDQA missions to improve data quality, it will provide quality indicators for the IPTp. Drawing lessons from the digitalization of LLIN campaigns, the management of the SMC data will be digitalized.

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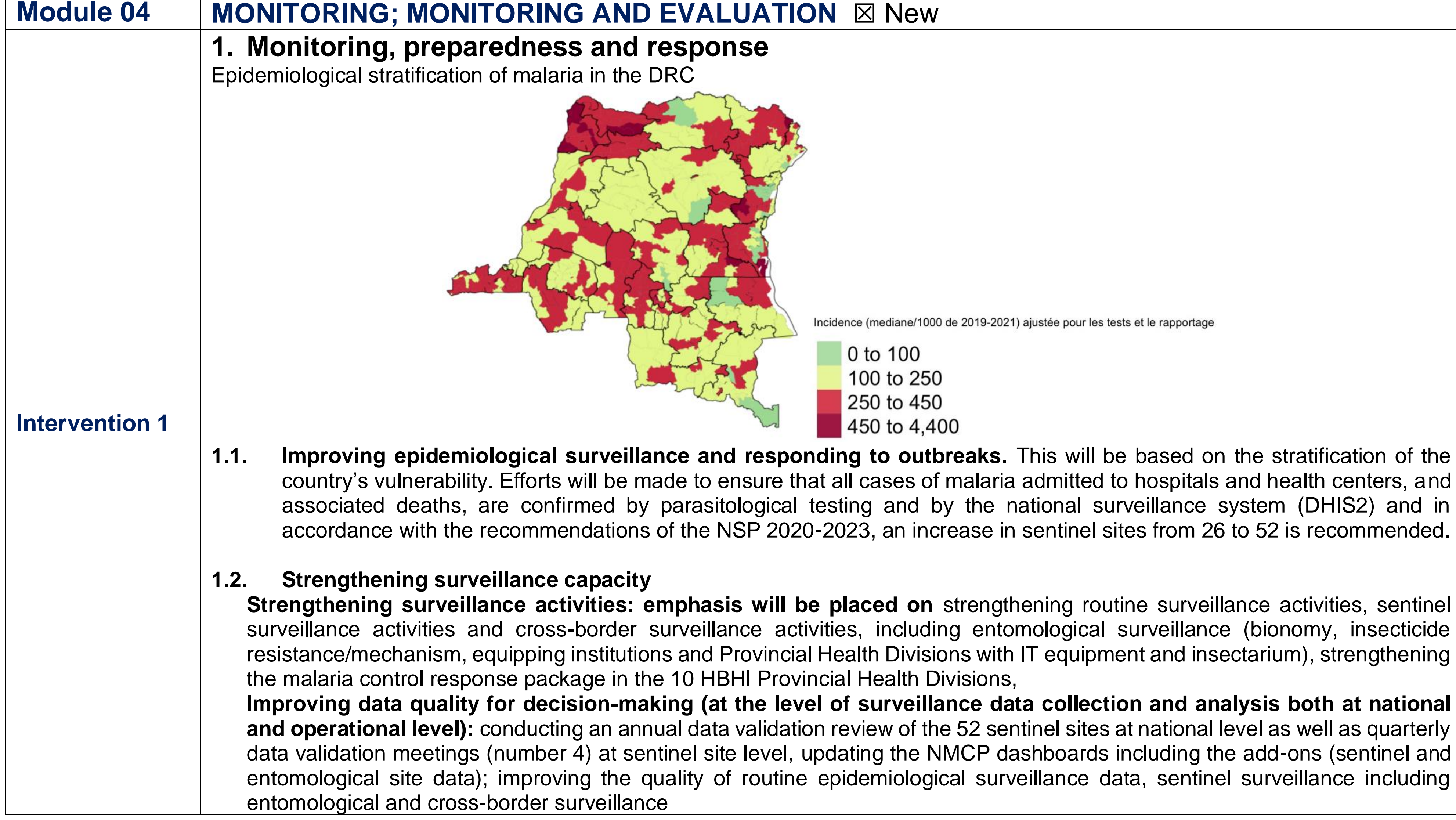
Module 04 | **MONITORING; MONITORING AND EVALUATION** ☒ New

Intervention 1

1. Monitoring, preparedness and response

Epidemiological stratification of malaria in the DRC



1.1. Improving epidemiological surveillance and responding to outbreaks. This will be based on the stratification of the country's vulnerability. Efforts will be made to ensure that all cases of malaria admitted to hospitals and health centers, and associated deaths, are confirmed by parasitological testing and by the national surveillance system (DHIS2) and in accordance with the recommendations of the NSP 2020-2023, an increase in sentinel sites from 26 to 52 is recommended.

1.2. Strengthening surveillance capacity

Strengthening surveillance activities: emphasis will be placed on strengthening routine surveillance activities, sentinel surveillance activities and cross-border surveillance activities, including entomological surveillance (bionomy, insecticide resistance/mechanism, equipping institutions and Provincial Health Divisions with IT equipment and insectarium), strengthening the malaria control response package in the 10 HBHI Provincial Health Divisions,

Improving data quality for decision-making (at the level of surveillance data collection and analysis both at national and operational level): conducting an annual data validation review of the 52 sentinel sites at national level as well as quarterly data validation meetings (number 4) at sentinel site level, updating the NMCP dashboards including the add-ons (sentinel and entomological site data); improving the quality of routine epidemiological surveillance data, sentinel surveillance including entomological and cross-border surveillance

	The study on the evaluation of the capacity of digital readers in interpreting the results of Malaria RDT in 144 health training courses in 3 provinces of PMI intervention revealed differences between the positivity rates reported in the HMIS and through the reader. Artificial intelligence could be used at a few sentinel sites, particularly to strengthen the monitoring system by measuring the accuracy of RDT results and ensuring the quality of the use of RDT. **Strengthening human resources capacity (national and operational): this mainly involves organizing** surveillance training (sentinel sites, entomological, malaria diagnosis and guidelines for management and training the RECOs in integrated surveillance at Community level (see HSS); organizing training for the 625 NMCP/SPD and SPD Health Zone actors of the 25 Provincial Health Divisions on the management of malaria data (collection, analysis, use of data for decision-making (DHIS2, Table/scorecard) and data quality assurance, except the Haut Katanga already trained; and finally, Supervision at the 52 sentinel sites. Organize training of actors on mass treatment campaigns to prevent epidemic response in areas with epidemic potential (ref 17). **1.3. Preparation Outbreak Detection and Response:** Particular emphasis will be placed on strengthening investigation and response activities for the management of epidemics, this component will take into account forecasting, early detection of alerts, and epidemics, or resurgence of malaria cases in vulnerable areas and during complex emergencies. A common contingency plan will then be drawn up. This plan will define the essential actions, the material, logistical, human and financial resources to put in place the emergency procedures for rapid intervention operations. The plan also takes into account specific (planned) campaigns to control a malaria epidemic within 15 days. For Provincial Health Divisions with seasonal outbreaks, arrangements are made to pre-position inputs needed to manage cases in a timely manner as part of the response. It is therefore important that efforts in timely identification and response to outbreaks are reflected in the funding request. In addition, in areas with epidemic potential, the grant will enable mass treatment of the population and control of the malaria epidemic. In the space of 6 years, some Provincial Health Divisions such as Sankuru, Haut Uele, Tanganyika, North Kivu, South Kivu, Ituri have experienced at least 2 reported outbreaks (source: National Plan for Preparedness and Response to Malaria Epidemics in the DRC (ref 18 response plan) To also strengthen the detection and response to malaria, but also other diseases, the NMCP will be able to work with the National Health Information System Division on interoperability between different campaign management platforms and DHIS2, as well as the establishment of a dashboard that would facilitate the use of data collected through digitization of campaigns.
List of activities	● **Improving epidemiological surveillance and responding to epidemics.** New activities (1) Stratify the country's vulnerability (update or validate the stratification work already done), (2) Evaluate the specific interventions offered to vulnerable populations. (3) Reinforce the analysis by Dashboard,

	● **Strengthening surveillance capacity: strengthening surveillance activities** New activities : (1) Equip institutions, Provincial Health Division and Health Zones with IT equipment and insectarium, (2)promote digitalization and rapid detection of epidemics ● **Improved data quality for decision-making (at the level of monitoring data collection and analysis both at national and operational level)** New activities: (1) Strengthen cross-border surveillance, (2) Organize a residential workshop between NMCP and Directorate of the NHIS on interoperability between campaign and DHIS data management platforms. ● **Human resources capacity-building (national and operational)** New activities : (1) Develop guidelines on IRS and cross-border surveillance, (2) Organize training on cross-border surveillance, (3) Organize training for actors on mass treatment campaigns to prevent outbreak response in areas with epidemic potential. ● **Epidemic preparedness, detection and response** New activities : (1) Pre-position inputs for timely case management as part of the response at the level of Provincial Health Division at risk of epidemics or seasonal resurgence (Sankuru, Haut Uele, Tanganyika, North Kivu, South Kivu, Ituri): (2) Create a framework for collaboration with meteorological services and academic institutions (e.g. ISTA, etc...) for malaria epidemic forecasts: (3) Organize the post-epidemic assessment; (3) Perform IRS in residential homes in the event of a malaria epidemic
Priority populations	- Population in highly vulnerable areas - Populations living in high altitudes or mountainous areas
Intervention 2	**2. Monitoring and evaluation** ● **Monitoring and evaluation will be carried out at all levels of intervention implementation,** and allows progress towards malaria control objectives to be assessed. Thus, emphasis will be placed on regular monitoring of the implementation of malaria control interventions and periodic (monthly/quarterly) analysis of key indicators for all actors including health zone managers, health facilities (public and private) and community care sites for performance assessment. The NMCP will organize the mid-term evaluation of its 2024-2028 National Strategic Plan. There is a need to use data for decision-making and to improve epidemiological surveillance and response to epidemics. The monitoring system will be strengthened at all strata level (as recommended by the TRP). Efforts will be made to diagnose and treat all cases of simple malaria at the level of all facilities and at the community level. At the level of all hospitals, the search for causes of death will be given particular attention and will be reported through the national surveillance system (DHIS2). The production and use of quality data should be a priority. To this end, in collaboration with PMI, the indicator monitoring dashboards and the malaria data analysis guide will be updated and adapted for easy use at all levels of the health pyramid. Malaria data quality control procedures using the Malaria Routine Data Quality Assessment (m-RDQA) tool will be standardized.

	Quarterly data quality monitoring missions will be organized. Emphasis will also be placed on strengthening the capacity of NMCP stakeholders (provincial and central) in monitoring and evaluation. Periodic data analysis meetings will be organized at the national level and in the 17 provinces supported by the Global Fund: monthly monitoring meeting at the level of the Health Zones (HSS), monthly/quarterly data analysis meeting at the national and provincial level, an annual review of data review will be organized as well as semi-annual reviews at the level of the 17 Provincial Health Divisions to question the malaria data. As part of the coordination of monitoring and evaluation activities, quarterly monitoring and evaluation thematic group meetings will be held at both provincial and national levels. ● **Conduct of studies and cross-sectional surveys** It will highlight an independent assessment of the lack of progress on lasting impacts, including the reasons for rising malaria cases and deaths. Testing of therapeutic efficacy of antimalarials at sentinel sites and monitoring of insecticide resistance, studies on the sustainability and bio-efficacy of nets will continue in the provinces with the collaboration of PMI. Continuing the study on the rate of positivity of Rapid Screening Test (RDT Malaria) carried out by PMI, a study on the deletion of RDT to the HRP2 protein will be considered during this phase.
List of activities	● **Follow-up Evaluation** New activities - Organize semi-annual/annual malaria data validation meetings - Conduct malaria data management oversight from the national level to the provinces, and from the provinces (17 supported) to the Targeted Health Areas - Organize quarterly Provincial Health Division routine malaria data quality control (mRDQA) missions to Health Zones, and experimentally from targeted Health Zones to Health Areas - Disseminate the quarterly Malaria newsletter nationally and in 17 provinces with Global Fund support - Organize training of NMCP actors at all levels in all 26 Provincial Health Divisions on data management Malaria (Data collection, analysis, use) - Improving the availability and circulation of quality health information - Establish sentinel sites in hospitals and strengthen the search for causes of death ● **Operational Research** New activities - Conduct an independent assessment of the lack of progress on the sustainable effects of the LLINs; - To carry out a study on the sustainability and bio-efficacy of nets, - Conduct an entomological study on the presence or absence of Anopheles Stephensi in the DRC

Amount requested	**Monitoring and Follow-up Evaluation - $3,312,762**
Expected outcome	• An operational data collection and analysis system in place • Adequate and available human resources for monitoring • An adequate system for epidemic preparedness and response • A contingency plan developed, validated and funded
Specify how the accuracy and reliability of the reported results will be ensured	Surveillance of the malaria epidemic is an area of interest to several partners working to combat the disease. In addition to the malaria program, other services such as emergencies, the epidemiological surveillance division of the DGLM is interested in malaria data and as such processes the same data with the same tools.

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Module 05	Program Management ☒ Renewal
Intervention 1	**1. Strengthening the administrative and technical management of the Program**: ☒ Intensification Particular attention will be paid to: (1) ***the steering bodies*** *resulting from the decentralization of the health sector from the national to the community level*: at the national level the National Steering Committee of the Health Sector; at the provincial level the Provincial Steering Committee of the Health Sector; at the operational level the Board of Directors, the Management Committee, the Management Committee, the Health Area Development Committee and the Community Animation Cell.(2) ***the reform of the health sector***: which at the national level links the Specialized Services (Programs) to the central Directorates and at the provincial level links the Provincial Coordinations to the Provincial Technical Support Offices of Divisions of Health. Under the current health system reform, all programs targeting infectious endemics in NMCP cases are coordinated by the Directorate General for Disease Control (DGLM). These programs and directorates report to the Secretary General of Health, who in turn reports to the Minister. (3) ***the planning, implementation and evaluation phases***; (4) ***national policies*** that align with international malaria control guidelines. The program at the national and provincial level will be responsible for supporting the Health Zones, which are the operational units, in the planning cycle of the malaria interventions as defined in the national policy. During this planning exercise, community representatives will be actively involved in identifying priority interventions to take ownership of the malaria response. This will be done by empowering local associations, health workers and committee members to plan and implement community-based interventions with the support of NGOs. To this end, a contractual arrangement with the grass-roots community organizations is envisaged on the basis of work plans validated by the local committee and the MCZS.

	In the context of malaria control, the analysis of the situation identified weaknesses that will need to be addressed to achieve good performance in the implementation of activities. These are: (a) poor working environments at national and provincial level that facilitate the achievement of results; (b) insufficient material, financial and other resources due to the low mobilization of local resources, including government financial allocations; (c) failure to assess staff performance since the outbreak of COVID-19; (d) low motivation of staff due to working conditions and the treatment of staff; Apart from the above, staff working in the fight are confronted with obstacles and inequalities including: administrative and political burden in the implementation of activities; complex procedures of the different partners as well as the non-harmonization of treatment of staff working in the fight against malaria by partners.
Activities	Continuation and intensification: See NFM3 funding request - Strengthen: (a) intra- and inter-sectoral collaboration: Directorate of the NHIS, DGLM, Environment, Urban Planning, Interior, Education; (b) Strengthening the health system in all sectors (public, private and community); (c) the capacities of staff in several areas that can contribute to the fight against malaria (Public Health, Malaria, Management of the fight against malaria, Leadership and Governance, Research Action, etc.); - Refresh stakeholder maps & interventions as well as health zones with community care sites New activities - Organize at all levels of the health pyramid: (a) pre-implementation planning workshops; (b) monitoring missions to improve the quality of malaria control; (c) periodic reviews of program data; (d) quality data reporting system for timely decision-making; (e) annual intra- and international review and exchange of experience missions; (f) workshops for the development and adoption of guides, guidelines, policies and good practices; (g) global and scientific malaria days; (h) advocacy sessions to the Politico-Administrative Authorities for the mobilization of funds (at the level of the National and Provincial Assembly), for the stability of the trained personnel and the respect of the deployment plan of the agents registered to fight; (i) awareness sessions of pressure groups (Agents, Parliamentarians, members of the Government, etc - ***Rehabilitate the National NMCP headquarters and ensure operating costs: PMI provided resources for the equipment of the new NMCP headquarters, including computer equipment;*** - Provide means of transportation for the implementation of interventions (vehicles, motorcycles and bicycles).
Amount requested	**Program Management - $63,182.191**
Expected outcome	✓ Strengthened program coordination at all levels of the health pyramid to ensure the provision of quality care and services ✓ Improved program management and performance at all levels of the health pyramid ✓ NMCP Unit and Division Officers assessed on the basis of RDTs of their positions
Intervention 2	**2. Improving Institutional Communication** ☒ Intensification

<table>
<tr><td></td><td>The NMCP has decided to put in place an important communication component to engage populations in health-promoting behavior. But it is also important to improve the institutional communication of the program in order to improve the visibility of achievements in the context of the management of the fight. Within the specific framework, the NMCP plans to align certain improvements such as gender, equity, equality, vulnerability and other aspects to increase the coverage of activities.</td></tr>
<tr><td>List of activities</td><td>- Continuation and intensification
- Develop and implement a communication plan as appended to the NSP
- Ensure: (a) website management and social networking for the NMCP, (b) identification and engagement of CSOs promoting girls' rights in malaria programs; (c) quarterly publication of NMCP-INFO magazine;
New activities
- Organize: (a) workshops on gender, gender equality, vulnerability and others (b) accountability meetings with political and administrative authorities and civil society, (c) meetings of the multisectoral communication framework for malaria control;</td></tr>
<tr><td>Amount requested</td><td><table><tr><td>institutional communications</td><td></td><td>$ 575 822,55</td><td></td><td>GC7</td></tr></table></td></tr>
<tr><td>Expected outcome</td><td>✓ Malaria information is disseminated and used by all stakeholders;
✓ Addressing gender equality, gender and vulnerability;</td></tr>
<tr><td>Specify how the accuracy and reliability of the reported results will be ensured</td><td>The NMCP has full responsibility for planning and implementing the activities set out in the different work plans, but other partners at all levels must also be transparent and accountable to the authorities and partners.</td></tr>
</table>

9

Section 2. Matching Funds (if applicable)

If Matching Funds were designated for the 2023-2025 allocation period:

Question 2.A: Describe how integrating Matching Funds will increase the impact and improve the outcome of the allocation for the Matching Funds area. Recommended page length: 0.5 page per matching funds area

Question 2.B: If Matching Funds were designated for the 2023-2025 allocation period, describe how programmatic and access conditions have been met. (1/2 page).

Section 3. What has changed? Update on the epidemiological context and national policies and strategies

Epidemiological background of the country

Question 3.A: Have there been any significant changes to the country's epidemiological context since the last funding request? Yes or no: Have there been any significant changes to the following items since the last funding request? 0.5-1 page per component

☒ Yes ☐ No

The epidemiology of malaria remains essentially unchanged with 97% of the population living in areas with stable malaria characterized by equatorial and tropical facies and 3% remaining living in mountainous regions of eastern DRC where malaria is unstable and at risk of epidemics.

From 2018 to 2021, the incidence of malaria continued to increase, from 177 to 185 new cases per 1,000 inhabitants, and the proportion of children aged 6-59 months with malaria infection from 31% to 48%.

During the same period, the notable change was in the reversal of the death curve with a 25% increase in malaria-related deaths and a 11% rise in malaria-related hospital deaths per 100,000 inhabitants, compared to a downward trend so far. This is mainly due to the weakening of the health system, reduced use of services and reduced malaria-related activities in support of the COVID-19 response after the onset of the pandemic, as well as the strike of health workers that paralyzed health facilities and activities for almost 6 months in 2021 and even much of 2022. A study will be conducted by early April 2023 in the health facilities and in the central offices to better understand this increase

As these two major factors are external to the malaria interventions themselves, the major interventions in place will be strengthened taking into account the recommendations of the 2022 Program Performance Review.

Certain factors may be considered because they may contribute to an increase in malaria cases. These include the impact of investments in strengthening the health information system with good data collection quality. Thus, a good completeness of the quality data in the DHIS2 is currently observed, which exceeds 90%. On the one hand, partners like PATH are supporting the NMCP for continuous data analysis across the DASHBOARD countries. On the other hand, a PMI study shows that there is a link between the reporting and the increase in cases that may be justified by an increase in the number of health units (health facilities) reporting on DHIS2 and the improvement in the completeness of the health facilities reports.

The contribution of community care sites can be explained by their increase in number between 2018 and 2021 from 6,969 (with 1,857,881 RDTs completed) in 2018 to 9,349 (with 2,109,028 RDTs completed) in 2021. In addition, the private sector is increasingly contributing to the malaria control framework, particularly case management and reporting at the DHIS2 level.

As regards mortality, it should be noted that, in addition to improving the quality of case management with systematic biological confirmation, improving the notification of cases of death, provision is made for the audit of malaria-related deaths,

Question 3.B: Have there been any significant changes to the following items since the last funding request?
Normative guidance or technical approaches adopted within the national policy or strategy for the program since the last funding request? Yes or No. **(1/2 page)**

☒ Yes ☐ No If **Yes to either**, explain how these changes will impact the existing program.

- ❖ In terms of vector control: Following the updated mapping of vector resistance to insecticides, the country has moved away from the standard LLIN to PBO LLINs and dual-treated LLINs.
- ❖ Vaccination: During the next grant, the country will introduce vaccination into its prevention toolkit under GAVI and Government co-funding.

- In terms of the case management: In line with WHO recommendations, the program will adopt the use of four ACT molecules with a phase-in plan. In areas with AL resistance markers, AP and ASAQ will be introduced in urban settings, representing 30% of the need. In rural areas, ASAQ and AL will meet 70% of the needs. In areas where no markers of resistance to AL have been found, AL will be introduced for children's case management, 32% of the rural area. DHA-PQ will be used primarily for epidemic response. Furthermore, in order to expand the services provided at community level, in addition to community care site coverage, the following have been selected: (1) set up a mobile relay at each community site to provide home treatment (2) carry out monthly mobile consultations at each health facility in vulnerable health areas and broaden the involvement of the private sector in the management of malaria cases.

Section 4. What hasn't changed? Maintaining relevance and impact

Question 4: Explain how the current program continues to be relevant and is on track to achieve results and impact (1 page).

- The country has not fundamentally changed its approach to malaria control. Notwithstanding vaccination, the basic interventions remain the same in terms of prevention including vector control through promotion of the use of LLIN and preventive treatments, case management through biological confirmation and treatment of cases and strengthening of surveillance. However, in these core strategies, significant technical adjustments were made as indicated in the previous section.
- In order to achieve results and impact: (i) Significant emphasis was placed on **communication, leadership and community engagement in a cross-cutting way** to boost community ownership of interventions. (2) **The collection and processing of quality data enabling factual and temporal decision-making, including the digitization of mass campaigns**. Particular emphasis is placed on epidemiological surveillance, which remains a well-strengthened pillar consisting of several interventions including routine surveillance, sentinel surveillance, entomological surveillance, vector and parasite resistance surveillance, outbreak or outbreak management, cross-border surveillance and community-based surveillance. (3) **Extending the coverage of case management interventions in the private sector**. Launched in July 2019, this private sector intervention aims to improve the availability and affordability of high-quality RDTs and ACT in for-profit pharmacies and health facilities in 7 cities with a population of nearly 16 million, followed by an extension to 6 new cities with the GC7 grant.
- **Lessons learned from the implementation of GC7 will help address challenges and barriers**: (1) The updated malaria risk and burden mapping has allowed stratification at the lowest possible administrative level for interventions tailored to each context; (2) mapping of malaria vector resistance to insecticides has helped guide the distribution of PBO and dual-treated LLINs according to their effectiveness to local vectors in different provinces; (3) Logistical constraints and accessibility issues of provinces will be taken into account in the distribution planning of LLINs in order to respect the renewal cycles of LLINs and reduce them to 24-30 months in accordance with local LLIN sustainability data; (4) The results of the TFWs have helped align drug policy with the first multiple line recommended by WHO; (5) Mechanisms to build the capacity of providers and communities are identified with the aim of maintaining an optimal level of implementation of malaria interventions in a crisis, based on lessons learned from the COVID-19 pandemic; (6) The DRC being categorized as a "country with challenging contexts of interventions", measures based on innovation, greater flexibility and partnership are put in place to improve the effectiveness of grant implementation (This includes the activity-based contract (ABC Approach) in the management of the LLIN mass distribution campaigns, an update of the risk mapping with risk mitigation plans for all PRs and SRs, a mapping of the streamlining of procedures followed by the dissemination of simplified procedures manuals with accompanying PR MPH by an FA whose RDT is to strengthen the MPH's capacity in grant management); (7) CSOs are involved in grant management from planning to implementation and strategic monitoring of grant implementation. This ensures access to interventions for the entire population, including vulnerable and marginalized populations, and strengthens the consideration of equity, sustainability and sustainable impact in the implementation of grants; (8) Strengthening community dynamics will enable the community to regain decision-making power.

Section 5. Strategic Focus Areas

The Global Fund has approved a new Strategy. Explain whether program design, implementation arrangements and budget need to adapt to fulfill the following Strategy objectives.

Questions 5A, B and C: Are the strategic objectives below already addressed within the current grant(s)? Yes/No/Partially: **0.5 page for each answer "No" or "Partially "**

Strategy objectives	**Already addressed within the current grant(s)?**	**If other efforts or adjustments are required for the period 2023-2025 allocation, please** summarize them here

A. Maximize people-centered integrated systems for health	☐ Yes ☐ No
	X Partially
		The DRC continues to work on integrating services to make access to care for patients as simple and inexpensive as possible:
		- Since the NMF2, significant efforts have been made to **ensure the effective integration of HIV and TB services to patients**, with the introduction of the one-stop shop. The latter allows patients to obtain services in the same health facility, and at lower cost. This was combined with a revision of the reporting tools of the National Program for Reproductive Health (PNSR) where the HIV variables to be captured for prevention of mother-to-child transmission were integrated. For community care sites, this grant is intended to integrate TB services (with screening for signs of TB and referral to the testing center) and HIV services with rapid testing and even self-testing, and referral to the care site.
		- Since 2020, the health system strengthening grant has been invested into an integrated package of Community outreach workers to cover the integrated management of childhood illnesses and the 3 pandemics. The training of community outreach workers RECOS and their actions are now cross-cutting; in addition, the community-led monitoring implemented in 3 provinces (Maniema, Kinshasa and Kongo central) targets the 3 pandemics, and goes beyond the services offered at the health facilities.
		- The National AIDS Control Program (NACP) also includes funding for the joint establishment of a referral system with the Blood Transfusion Program to track suspected HIV positive cases among blood donors on the first test, blood transfusion units to testing sites, and HIV case management (tests are provided by the National Blood Transfusion Center (CNTS)).
		- In the area of monitoring and evaluation, work will continue and be completed to integrate the data produced by the Community stakeholders into their work with the target population. This is important work, to which the Directorate of the NHIS has already committed, and will provide valuable additional information on the health status of the population, as well as on the activities of community care sites and community-based organizations.
		- The grant continues the work of establishing community-based care sites, which provide maternal and child health and malaria care to patients living in rural areas and more than 5 kilometers away.
		- In addition, the efforts initiated during this cycle will be continued to better understand the characteristics and determinants of access to care for the most vulnerable and marginalized populations and to propose activities adapted and commensurate with their expectations:
		    - **The TB grant** provides for the mapping of vulnerable populations (indigenous populations, refugees/internally displaced) and the implementation of screening activities with digital radiography. It will also implement community-based directly-observed treatment to prevent patients from having to travel daily to health facilities (FOSAs), with the cost and stigma they often face.
		    - **The malaria program** had begun a stratification approach by type of vulnerability as part of NMF2 cycle, and then intensified it. In this context, the stakeholders carried out an assessment of the degree of vulnerability of the groups considered to be the most marginalized or fragile in the country. These include populations affected by epidemics,

		internally displaced people and refugees, minority populations (e.g., Pygmies), prison populations, street children, children in vulnerable situations (OVCs: Orphans and Vulnerable Children), women in vulnerable situations, artisanal mining populations. For all of these populations identified as vulnerable, a more detailed examination of specific barriers is conducted, such as: socio-cultural barriers, barriers related to low availability of health services, and geographic barriers. Specific approaches to reaching them have been developed in response to this needs assessment and preliminary results of the MATCHBOX survey: - **Community-based intermittent preventive treatment (TPI)** for Pygmies and pregnant women (extension of the TIP TOP project: Transforming Intermittent Preventive Treatment for Optimal Pregnancy), which allows for administration of intermittent preventive treatment (IPT) at the community level (a pilot project for which the WHO is awaiting evidence) while encouraging women to visit a health facility (FOSA) for full pregnancy follow-up. - **For the prevention and care of street children**, the program will involve associations for children in vulnerable situations: (OVCs: Orphans and Vulnerable Children) for assistance for case management through health centers. All stakeholders will benefit from a free enhanced care session on caring for street children; focal points at the association level will benefit from training and input for the care of street children. Lastly, the aid associations will receive financial and technical support to carry out an information, education and communication activity among street children on the availability of services for the prevention and management of severe malaria in prison settings; it is envisaged to review the technical platform of health facilities (FOSAs) and, finally, for artisanal miners, mobile health clinics will be used - **HIV activities** are also largely guided by a focus on taking into account the specificities of patients, and offer many actions that put them at the center. Certain segments, in particular key populations, pregnant women and newborns, are considered by the program to be top priorities for the GC7, hence the revitalization of community activities or the implementation of additional approaches: - **The grant will revitalize community-based activities** (mentor mothers), develop differentiated approaches to the delivery of antiretrovirals in groups of HIV+ pregnant women, provide weekly follow-up of HIV+ cases to benefit from antiretrovirals, provide coaching and monitoring in high-loss Provincial Health Divisions, and build capacity for high-loss health care facility providers. - Counseling activities and the establishment of community listening and exchange clubs make it possible to learn about the problems faced by people affected by HIV, and to adapt the services offered to them to the greatest extent possible. - Lastly, the program also proposes specific approaches for certain vulnerable groups: - Support for mechanisms to strengthen links to health facilities (FOSAs) for refugees, migrants and internally displaced persons diagnosed with HIV+ or Tuberculosis in the community (referrals, support, compensation...) in the 10 Provincial Health Divisions affected by conflict or insecurity. - Support for mechanisms to strengthen ties with miners and members of the mining community tested during the advanced strategy using mobile units, the community and care structures (referrals, support, compensation...) in the 10 Provincial Health Divisions with intense mining activity. - Active TB screening campaigns in slums were also conducted as part of the current cycle through Digital Radiography and will continue as unsanitary neighborhoods provide fertile ground for the spread of TB.

B. Maximizing the engagement and leadership of the communities most affected	☐ Yes ☐ No X Partially	The engagement of the most affected communities continues with this grant. Communities, in all their forms, are heavily involved in expressing needs, delivering services, ensuring continuity of care, and monitoring health services. To this end, the grant provides for a number of activities to strengthen and support community players: - **All community engagement activities funded through the Health System Strengthening (HSS) grant contribute to strengthening civil society actors**, whether they are community volunteers (known as RECOs) chosen from villages and neighborhoods, peer educators, or members of community-based organizations. With the NMF3 grant, community engagement and leadership activities began through the revitalization, establishment and strengthening of community participation structures (community activity coordinators (CACs) and health area development committees [CODESAs]) and civil society actors. Civil society is involved and works closely with community participation bodies (CACs at village/street level and CODESAs at health area level), these structures report weekly to the Health Center team for good coordination and community monitoring of activities to ensure the transmission of valuable information on the health status of the population to ensure quality care. The involvement of the community and its leadership in satisfaction surveys for users and their support persons is a key illustration of this, not to mention the suggestions it makes through the suggestion box. - However, in order to leave no one behind, it has proved important to involve other civil society actors in the intelligence, design and execution of high-impact interventions that can empower their roles at the local level. This allocation will include activities to map civil society organizations, networks and platforms, their institutional and organizational enhancements and their structuring into more inclusive platforms. This will allow for meaningful participation in decision-making and will benefit implementation and intervention monitoring in a consensual and inclusive approach. This good coordination of community actors will make it possible to use evidence-based advocacy with health and politico-administrative authorities to address the persistent barriers to health care related to HIV, malaria, COVID-19 and other health problems of the most affected populations. - **In the delivery of services and the links with care**, many structures are present and work: - **Provider Community Volunteers (RECOs)** or Recosites are responsible for testing and treating patients with uncomplicated malaria fever. They are making the link with health facilities (FOSAs) for complicated malaria. They collect sputum from patients with signs suggestive of TB, refer suspected cases to health facilities (FOSAs) for screening and, if needed, initiation of treatment, and support them in community-based directly-observed treatment. They receive training, have basic equipment to work with (thermometers, scales, blood pressure equipment, rapid malaria tests, spittoons and packaging), and are supervised by a nurse. They participate in the various existing community platforms (community activity coordinators (CACs) and health area development committees [CODESAs]) and link the communities to the first level health facilities (FOSAs). - **There are many peer educators**: mentor mothers (who support pregnant women during pregnancy and after childbirth to screen and treat newborns), key peer educators, prison workers (selected from among detainees), internally displaced people (IDPs) and refugee camps, mines, miners and their families. In addition, the installation and expansion of antiretroviral distribution points ensures community distribution in a user-friendly setting, where people living with HIV are welcomed by their peers, counseled and participate in discussion or support groups. - **Actions with specific key groups** have already begun during this cycle and will be intensified in GC7, due to the concerning figures emerging from the bio-behavioral study (IBBS), including access to information, prevention, stimulating demand for the use of pre-exposure prophylaxis, adhesion support, and linking to care facilities.

		- **In community-led monitoring,** there are now three ways to monitor the accessibility and quality of health services available to the population:
		  - One Impact, implemented by Amis Damiens, for community monitoring in the field of tuberculosis in 5 provinces (Kongo Central, Kinshasa, La Tshopo, Kasaï Oriental, Kwilu and South Kivu)
		  - The Observatory, managed by the Congolese Union of People Living with HIV (UCOP+), which monitors HIV and tuberculosis activities in three provinces (Kinshasa, North Kivu and Kasai Oriental)
		  - Community-led monitoring in Maniema with Fondation Femmes Plus, and in Kongo Central and Kinshasa with the Coordination Team for Community Systems Strengthening (CNRSC). It integrates the 3 pathologies and in Maniema, supports the pilot and direct funding for health training.
		
		In addition, communities are engaged in health product supply processes and exercise leadership in monitoring drug availability in health facilities (FOSAs) and community care sites. Indeed, no delivery of medicines can take place at the peripheral level without the Community Representative (CAC). A representative of health area development committees (CODESA) participates, in theory, in the data monitoring meetings, but they do not yet participate in the meetings of the Working Group on Medicinal Products.
		
		We plan to improve this situation in GC7, with systematic participation of a CAC member in the monitoring meetings and in the meetings of the Working Group on Medicinal Products. On the one hand, this participation will allow the community to have a better view of their health problems and the way they analyze them. In addition, it allows for feedback to community platforms (CAC and CODESA) on the health of its population and the emergencies to be addressed.

C. Maximizing equity in
 	
health matters,
 	
gender equality and
 	
human Rights.
	☐ Yes ☐ No
	
	X Partially
		The issue of equity, gender equality and human rights is multi-dimensional and remains a challenge in the DRC. Efforts have been made in previous rounds, and there are now a number of important documents in this area in order to make a diagnosis of the situation: evaluation of the legal framework for the response to HIV, the stigma index of key populations and of people living with HIV and persons affected, gender-specific evaluation of the HIV-tuberculosis response, rapid evaluation of the tools of key populations of tuberculosis in the DRC, etc.
		
		On Human Rights:
		
		Despite all this legal arsenal, people living with HIV, TB patients, survivors of gender-based and sexual violence, and key populations and other vulnerable groups still face barriers to accessing HIV-and TB-related health rights, and other related services due to misinterpretation of certain legal texts and cultural and religious weight. Progress was made during this cycle, which will be continued under GC7:
		
		- With the current round of funding, the country has developed **an integrated guide on fighting stigma, discrimination and human rights in healthcare and community settings**. The next allocation will include operationalization of the HIV/TB guide to combat stigma, discrimination and respect for human rights in healthcare settings, capacity-building for peer educators to combat self-stigma for health promotion, well-being and non-discrimination, discussion sessions on attitudes and practices of discriminatory and stigmatizing acts and behaviors for public and private health facility (FOSA) providers, legal clinics, victims of violence, key populations, TB patients and vulnerable rape survivors;
		- The TB program includes several core activities to elicit evidence of discrimination against people affected by TB:
		  - Assessing TB stigma across all sectors (public and private) with the Stop TB tool and developing the Operational Plan to Address TB Stigma;
		  - The study on TB stigma in the community, health, mining, labor, law and justice sectors (police, prisons, military);

		- support for grassroots associations of former TB patients and vulnerable key populations TB - Funding for TB Paralegals and Monitoring the Quality of Services by the TB Community In addition, citizen monitoring and satisfaction-reporting approaches will be put in place to combat stigma and discrimination, such as suggestion boxes in health facilities (FOSAs), abuse reporting software, and the use of the “mystery shopper” to assess the quality of HIV/TB care in health facilities (FOSAs). ***On gender and equality in grants:*** When considering and preparing funding requests, stakeholders asked themselves how men and women are affected by the three diseases, how they have access to information, services, resources to cover health expenses, what role they play in the home to promote health... For the Health System Strengthening (HSS) grant, several interesting reflections emerged and are listed here: - **In the field of community systems**: Community participation during NMF3 devoted a minimum of 30% to female participation. However, the equity, gender and human rights aspects were not sufficiently developed during NFM3. Thus, for the next allocation plans include influencing the country’s policies in this area by integrating into the community participation manuals the different training modules and tools, as well as aspects related to gender and human rights. Evidence from community-led monitoring on gender and human rights will serve as a basis for advocacy with authorities and decision makers to remove barriers related to inequalities in care for all vulnerable populations (LGBTI+, sex workers, injecting drug users, pregnant women, children under 5, persons with disabilities, etc.). In addition, community activity coordinators and other civil society stakeholders trained on the topic will carry out activities to promote respect for equity, gender equality and human rights for all and by all. - **For human resources**: health equity was discussed as socially acceptable care requires this gender reflection. Data available to date show that male staff make up 59% of the total workforce, while female staff make up 41%. Satisfaction surveys and feedback from community-led monitoring indicate that this is a barrier to the use of services, particularly for antenatal consultations of pregnant women. The activities of the HRH module take this issue into account in two ways: on the one hand, during the rationalization, the reflection on the acceptability of male staff to certain positions will be discussed and, if possible, with equal competencies, female staff will be encouraged. The same is true of positions of responsibility, whether administrative or medical, since today, of the 41% of women, most are in the lowest socio-professional categories. On the other hand, the training modules on primary health care will be reviewed with the help of a gender specialist from the gender unit at the Ministry of Health, in order to introduce the issue of gender equality in relation to illness and care. - **In the laboratory area**, the RESOH Laboratory project co-funded by the French Development Agency (AFD) and the Global Fund includes a gender component. At the end of the intervention, the RESOH-LABO project will have achieved the following results: · Women are integrated into laboratory and surveillance systems governance; · Access to quality medical biology tests is improved, especially for women

		· The surveillance system is strengthened and responsive in a One Health strategy; integration of gender data allows for a more targeted and socially relevant response; · Biomedical and socio-anthropological cross-awareness of risks and social determinants of endemics and epidemics is strengthened and used in public policy. - **With respect to the National Health Information System and the strategic use of sex- and age-disaggregated data,** the Directorate is committed to refining its disaggregated data as much as possible, especially for adolescents, who are at a critical age for combating new infections. In addition, when revising the format of data monitoring meetings at the health zone level, there are plans to include questions on gender analysis and corresponding epidemiological data. This will allow for a real reflection on the concerning data on maternal mortality, new HIV infections, which are twice as high among girls and women, and gender-specific data on cardiovascular diseases, which predominantly affect women. Likewise, data on violence against girls and women (including sexual violence) are not systematically reported, and so an effort will be made to systematically review the subject in meetings; in addition, providers and area head doctors will be made aware of the importance of providing information on this indicator to assess the extent of the phenomenon. This is a necessary prerequisite for effectively addressing sexual violence, which is a major vector of HIV and the transmission of sexually transmitted infections, as well as serious trauma and family rejection, especially when associated with unintended pregnancies. Lastly, some indicators related to gender equality and respect for human rights are being identified for inclusion in the District Health Information System (DHIS2). It will certainly take time, training and awareness-raising for data on them to be provided and analyzed, but this is a major issue of visibility of the issue and of its consideration for an institutional response, and no longer just a one-off action by civil society actors. - **For all three programs**, gender mainstreaming is an obligation, as socio-economic and cultural determinants influence the health status of girls and women, and guide their behavior in protecting their health and seeking care. There are many peer educators who work with women: mother mentors, women's associations, particularly the civil society stakeholders who develop communication strategies to raise awareness among women about infant and child health, the importance of proper use of mosquito nets, hygiene and prevention of diarrhoeal infection, community volunteers (RECOs), especially female, to look for women who do not attend antenatal consultations for administration of community-based intermittent preventive treatment (IPT), even though women were not found to be reluctant to disclose their non-apparent pregnancy to male volunteers during the TIP TOP pilot. - The HIV/TB grant has identified, through various studies, regular violations of the rights of adolescent girls and young women and foresees training for women, adolescent girls, young girls and key populations on knowing their rights for equitable access to HIV and TB services (school and out-of-school) in the 6 Hubs. It also provides for numerous awareness-raising activities on the issue of sexual violence, accompanied by a referral system to medical and psychosocial care facilities. - The TB program has included an indicator for the GC7 grant on the proportion of men and women among patients screened and treated. Monitored regularly, this indicator will provide information on further efforts to achieve equitable access to services for men and women. - Finally, to address **the fragmentation of the Provincial Health Division (DPS) funding system**, the Ministry of Health has introduced the coordination approach to supply chain investments and interventions. See Annex: Health Financing Mapping Report (second half of 2022)

		In terms of equity: It should be noted that equity has been a difficult topic in the current cycle: in the HIV response, and due to lack of resources, the targets to be met with the provision of HIV testing have been restricted to pregnant women in 15 so-called priority provinces, and pregnant women in the remaining 9 provinces have not benefited from this service. The same is true for key populations attending the 25 user-friendly centers, TB patients and contacts of HIV+ cases (in Global Fund Provincial Health Divisions) This situation has created a lot of frustration in the sector and in the community, and this new subsidy must avoid these situations of inequity as much as possible. For its part, the TB program has committed to providing information on two indicators of equitable access to treatment for miners and prisoners.
D. Pandemic preparedness	☐ Yes ☐ No X Partially	Since the outbreak of COVID-19, stakeholders of the DRC Global Fund grant have worked hard to adapt programs to new outbreaks that could disrupt routine testing and care. Mitigation plans have been developed to adapt activities and ensure continuity of care in case of disruptions such as partial lockdowns, border closures or difficulties in accessing health facilities (FOSAs). For example, programs have put in place measures such as door-to-door distribution of mosquito nets, delivery of multi-month antiretrovirals, community-based directly-observed treatment and Visio for patient follow-up during the next cycle. Similarly, the National Access to Medicines Program (NAMP) developed its strategic plan for emergency procurement, which did not exist before. It describes the role played by the National Access to Medicines Program in preparing for and meeting the needs of medicines linked to certain recurrent epidemics (cholera, yellow fever, Ebola, measles,…) and in pre-positioning kits in the most frequently affected Provincial Health Division (DPS). In terms of the information system, the Ewars system has been and will continue to be strengthened as it has proven its usefulness in the timely reporting of epidemic events, and interoperability with (District Health Information System (DHIS2) is being achieved. The pandemic preparedness and response actions introduced in the Health System Strengthening (RSS) request are in line with the DRC's Action Plan for Health Security, and prioritize WHO-recommended Integrated Surveillance for Infectious Diseases and Response (SIDR) training, the establishment of the National Center for Epidemiological Intelligence and its provincial versions, and community-based surveillance, delivered by community volunteers and selected community stakeholders (these activities were placed in the PAAR, pending funding from the remaining 2022 available envelopes). The significant laboratory scale-up to prepare the country to develop a provincial network of public health laboratories capable of detecting outbreaks and providing a decentralized service to avoid COVID-19 saturation, which was initially diagnosed only in Kinshasa, and genomic sequencing capacity in the provinces. The National Health Security Action Plan (PANSS) provides for these investments in the laboratory system (under the leadership of the Health Laboratory Directorate [DLS]), particularly those related to single health (oneHealth), a vision that includes projects such as RESOH-Labo and Regional Disease Surveillance Systems Enhancement (REDISSE), and the fight against antimicrobial resistance (AMR.) under the leadership of the Congolese Authority for Pharmaceutical Regulation (ACOREP).

		Lastly, it is worth noting the creation of the **National Coordinating Council for the Management of Epidemics, Emergencies and Complex Disasters**, which is the framework for consultation and decision-making placed under the authority of the Prime Minister, and that of **the National Institute of Public Health (INSP**) (Ordinance-Law No. 23/009 of 3 March 2023 amending and supplementing Law No. 18/O35 of 13 December 2O18 laying down the fundamental principles relating to the organization of public health) **(Annex 25).** Its main tasks are: - Ensure the implementation of specific interventions to reduce risks and respond to the occurrence of public health problems, epidemics, disasters and public health emergencies of national or international concern - Mobilize national and international expertise to support efforts to address the adverse effects of epidemics, disasters and public health emergencies; - Ensure the implementation of the International Health Regulations in the Democratic Republic of the Congo; - Provide the technical secretariat for the National Coordinating Council for the Management of Epidemics, Emergencies and Complex Disasters
E. Sustainability Are there major challenges to the sustainability of the national response?	☐ Yes ☐ No ☐ X Partially	The sustainability of the response goes far beyond the issue of financing the Global Fund, and this section provides elements that are not guarantees, but rather outlines policy, operational, and financial efforts to ensure services continue beyond Global Fund financing. **Institutional sustainability**: The three disease response programs are strong interlocutors nowadays able to produce strategic plans with a budget and mobilize resources from partners such as the Global Fund, but also USAID, PEPFAR, Japan International Cooperation Agency (JICA), Canadian Co-operation, Expertise France and the French Development Agency (AFD).... They have well-trained staff at the national level and focal points in each Provincial Health Division, namely the program physicians. Thanks to funding over the past 20 years, pandemics are a priority in the National Health Development Plan, and strong markers of the health of the country. **Operational Sustainability**: The Global Fund has secured funding to fight the three pandemics for 20 years. Its steadiness has created strategic and operational capacities that will last beyond the funding of an external donor. Strategic plans, therapeutic protocols and training providers are all intangible wealth created over the years of the response. They will last beyond funding from the Global Fund. **Financial sustainability**: The issue of financing health in the DRC is critical, and all the actors involved in the fight against the three pandemics have repeatedly reminded the State of its duty to put at the service of the Congolese people a resilient, sustainable health system accessible to the poorest. On the positive side, the Congolese state has respected its co-financing commitments for several rounds. On the other hand, the lack of investment in the system in general is regrettable. 90% of the funds are used to pay staff salaries, which are not even 100% covered. As for the rest, provincial health divisions need to rely on the support of partners to implement health activities. When a project is stopped, as was the case for Nord Ubangi, whose support from FCDO ceased, health services operate minimum provisions with their own resources. In Kinshasa, apart from funding for salaries, all services are funded by technical and financial partners. The recent commitments that the Head of State has made to the population on establishment of universal health coverage (UHC), one of the flagship components of which is currently free childbirth care, require much more government funding, hence the promulgation of the recent law explained below. For the three diseases, additional funding from the Ministry of Health does not cover the gaps identified: - For malaria, the budget allocated by the Congolese government was 2018 (33,000,733), 2019 (41,133,546), 2020 (37,693,212)

		and 2021 (41,733,352). This represents an annual average of 37,275,830. It is expected that the State will allocate for the next grant (NMF4) 239,041,078 in 2024, 298,970,904 in 2025 and 291,948,604 in 2026. - The table of matching funds shows that the Congolese government honors the payment of salaries and bonuses, as well as some infrastructure rehabilitation, but all the rest is borne by the technical and financial partners (TFPs), making the amounts allocated by the Global Fund indispensable and not very long-lasting. Recent decisions to implement universal health coverage should provide additional resources to the Ministry of Health. This is the meaning of the **Ordinance-Law cited above, which establishes the Health Promotion Fund**, a public administrative and financial institution with legal personality and management autonomy, to support the national health system. Its tasks shall be to: - finance health infrastructure projects, medical equipment and promote local production of specific medicines and inputs; - fund the promotion of traditional medicine; - fund the supply of essential medicines, including contraceptives, vaccines and other public health inputs; - fund health sector governance, planning, and human resources for health development; - subsidize health and pharmaceutical service and care establishments. The Health Promotion Fund is financed in particular by public funding and the contribution of communities, national and international solidarity, investments, authorized partners and a proportion of contributions to the compulsory health insurance scheme as well as by innovative financing. Innovative financing includes a share of mining royalties allocated to the central government, a health promotion tax set at 2% of the cost, insurance and freight value of imported goods, and a share of excise duties levied on unhealthy products, including tobacco, alcoholic, energy and sugar-sweetened beverages, and telecommunications. Great hopes are pinned on this reform, which should provide the health sector with domestic funds to support the roll-out of the roadmap for universal health coverage (CSU).

F. Domestic Financing and Resource Mobilization

The public health expenditures presented are those compiled from **January 1, 2018 to October 31, 2022.** They have been validated with the full participation of all actors involved in the Global Fund to Fight Malaria, Tuberculosis, HIV/AIDS projects for the period 2018 to 31 October 2022 (to show the commitments of the Grants of current and additional funding requested by the Global Fund).

This amount was committed by Treasury, but most of the contracts are not yet finalized and/or inputs have not been delivered. The Global Fund awaits all supporting documentation to validate all expenditures. Yet the Congolese government **is not failing to co-finance** Global Fund projects for the current 2021-2023 NMF3 funding grants for malaria, tuberculosis, and HIV/AIDS.

The Democratic Republic of the Congo through its Global Fund Project Co-Financing Monitoring Committee transmits annually data on government health spending in the fight against malaria, tuberculosis and HIV/AIDS, in accordance with letter N" 2930/CAB/MIN/Finances 2020 and N'1250 /CAB/MIN/S/ /DC/ 2020 of 04 December 2020 on the commitment of the Democratic Republic of the Congo to Global Fund Project Co-financing for the Global Fund for the Congo 2021-2023 addressed to the Executive Director of the Global Fund in Geneva/Switzerland.

This letter reaffirms the commitment of the Congolese Government to maintain the level of expenditure recorded during the period 2018-2020 and to carry out, in addition, additional co-financing investments of at least USD 64,493,579.00 for the period 2021-2023 for the fight against malaria, tuberculosis and HIV/AIDS.

The Congolese government that has received Global Fund grants has committed to demonstrate from cycle to cycle:

1. Increased public spending on health;
2. Increased spending on the three diseases and/or HSS;
3. Gradual absorption of the programmatic costs of programs to combat the three diseases;

Indicators	2018	2019	2020	2021	2022	Source
Budget allocation in million Congolese Francs						
State budget allocated to the Health Administration	681,715	1,026,734	939,391	1,649,609	1,727,511	ESB-Min Budget
State budget allocated to the Health Function	761,581	1,056,323	981,182	1,709,860	1,766,121	ESB-Min Budget
Overall State budget	8,927,876	9,604,891	9,788,533	15,331,382	20,408,331	ESB-Min Budget
% of the State budget allocated to the Health Administration	7.64%	10.69%	9.60%	10.76%	8.46%	
% of the State budget allocated to the Health function	8.53%	11.00%	10.02%	11.15%	8.65%	
Budget implementation in million Congolese Francs						
Implementation of State budget allocated to the Health Administration	420,768	573,085	635,916	874,746	524,850[1]	ESB-Min Budget
Implementation of State budget allocated to the Health function	508,835	603,622	658,746	922,403	577,206	ESB-Min Budget
State budget allocated to health administration implementation rate	61.72%	55.82%	67.69%	53.03%	30.38%	
State budget allocated to the Health function implementation rate	66.81%	57.14%	67.14%	53.95%	32.68%	

Source: Mini Budget/ DGPSB, ESB for 2018-2022 and MPHHP/NHANP NHA Report 2018-2021-DRC.

[1] ESB_MIN Budget, from January 1st to October 31, 2022

The public health expenditure shown in this table takes into account current health expenditure and health investment expenditure. Meanwhile, transfers from national revenues of the public administration only relate to current health expenditure.

As a result, there was a significant increase in health allocations and implementation in 2021 (and 2022) compared to the 2018-2020 average. This reflects the increase in absolute health budgets, even though the relative value remains well below Abuja and even looks to be declining.

As for implementation, we generally see an increase in the execution rate of public health spending between 2018 and 2020. Thus, an effort is being made by the Congolese Government in the financing of Health.

Public health expenditure on the fight against the three diseases and/or HSS

The table below shows the country's efforts to maintain and increase the level of public health spending on the three diseases in 2018-20.

Table 2 Evolution of Government health expenditure on remuneration and Health System Strengthening (RSS) for the 3 diseases

Diseases	Delivery Factors	2018	2019	2020	2018-20		2021	Sources
					Total	Annual average		
HIV	**Remuneration**	**28,928,189**	**37,015,653**	**36,899,010**	**102,842,852**	**34,280,951**	**40,591,569**	Global Health Expenditure Database (GHED) (2018 & 2019) / Report on GHED (2020)
	Other [1]	2,350,126	2,253,290	1,866,631	6,470,047	2,156,682	1,406,492	
	Subtotal	**31,278,315**	**39,268,943**	**38,765,641**	**109,312,899**	**36,437,633**	**41,998,061**	
TB	**Remuneration**	**936,010**	**1,167,891**	**1,132,862**	**3,236,763**	**1,078,921**	**1,326,882**	Global Health Expenditure Database (GHED) 2018 and 2019/GHED Report (2020)
	Other	148,253	218,021	282,897	649,171	216,390	159,830	
	Subtotal	**1,084,263**	**1,385,912**	**1,415,759**	**3,885,934**	**1,295,311**	**1,486,712**	
Malaria	**Remuneration**	**27,529,312**	**36,065,402**	**34,570,670**	**98,165,384**	**32,721,795**	**38,268,098**	Global Health Expenditure Database (GHED) 2018 and 2019/GHED Report (2020)
	Other	5,471,421	5,068,144	3,122,542	13,662,107	4,554,036	3,465,254	
	Subtotal	**33,000,733**	**41,133,546**	**37,693,212**	**111,827,491**	**37,275,830**	**41,733,352**	
HSS	**Health and Social Development Plan (HSDP)**	110,703,091	127,110,293	158,191,787	396,005,171	132,001,724	120,784,703	https://projects.worldbank.org/en/projects-operations/project-detail/P147555
	COVID-19	0	0	10,089,386	10,089,386	3,363,129	28,679,178	https://projects.worldbank.org/en/projects-operations/proj

								ect-detail/P173825)
	National Blood Transfusion Center (CNTS)							
	Subtotal	110,703,091	127,110,293	168,281,173	406,094,557	135,364,852	149,463,881	
Total		**176,066,402**	**208,898,694**	**246,155,785**	**631,120,881**	**210,373,627**	**234,682,006**	

The DRC is committed to maintain the level of public health spending on the three diseases in 2018-2020 and to increase that spending by a minimum of US$64,493,579 over the period 2021-2023 to US$21,497,859.67 per year.

The table shows that total public health spending by the Congolese government from 2018 to 2020 is US$ 631,120,881, or an average of US$ 210,373,627 over the three years. This means that in 2021 the country must maintain this level of spending and increase by at least USD 21,497,859.67. This results in a public health expenditure of at least USD 231,871,486.7 in 2021 for the three diseases and HSS. It can be seen that for this category of public expenditure the DRC realized an amount of $234 682 006 in 2021, an overshoot of 1.2% compared to the annual average.

3. **Gradual consideration of major programmatic costs**

The DRC has committed to purchase USD 12.9 million inputs for the three diseases over the period 2021-2023.

The inputs specified in the letter of commitment are ARVs, rapid HIV tests, GeneXpert equipment and/or cartridges, components of the CCM package (integrated community care), LLINs (notably for the Kinshasa 2023 campaign), adult Artesunate for injection of 120 mg.

For example, the table below shows the Congolese government's public health commitments and expenditures in the procurement of specific inputs for the three diseases over the period 2021-2022.

Table 3 commitments and purchases of specific inputs for the 3 diseases from 2021 to 2022

Program	Type of input	Amount committed by the Treasury		Amount with all supporting documents*	Amount remaining to be posted	Supporting documents	
		2021	2022			Purchase Order or Invoice	Delivery note
HIV	HIV rapid tests	843,245	-	-	843,245.0	No	Yes, Minutes dated May 2022
	03 Screening tests, determines, statpak, unigold, Purchases INPUTS viral load, Lab and Biology equipment and materials	-	3,342,408	-	3,342,408.0	No	No

	Molecular for Kindu and Mbuji-Mayi						
	S/Total	843,245	3,342,408		4,185,653.0		
TB	Reactive Purchases, Specific Laboratory Inputs and Consumables	522,000	-	-	522,000.0	No	No
	Drugs procurement		800,000	-	800,000.0	No	No
	GenExpert and Cartridges	359,184			359,183.8	No	No
	Microscope		400,000		400,000.0	No	No
	Total	881,184	1,200,000	-	2,081,183.8		
Malaria							
Total		1,724,429	4,542,408	-	6,266,837		

* To validate an expenditure incurred for the purchase of inputs, the Global Fund requires 2 types of supporting documents: (1) a purchase order, contract or invoice with the input types and the monetary value of the order; and (2) a delivery note or PO. The expenditure is then validated for the year of the commitment.

The DRC has committed to purchase USD 12.9 million inputs for the three diseases over the period 2021-2023. There are USD 6 266 837 / 12 900 000, **or 48.58%** of the specified inputs included in the letter of commitment: ARV, Rapid HIV tests, GeneXpert equipment and/or cartridges, etc. have been committed by public funds. Therefore, for the period 2021-2023, only USD 6,633,163.25 /12,900,000, **or 51.42%,** to be committed. Contracts committed in 2021 and 2022 will also need to be concluded through the delivery of inputs **Comparison of planned and realized expenditures in 2021.**

4. Other Government expenditure under co-financing

Program	Type of input	Committed amount (in USD)		Amount with all supporting documents	Amount remaining to be posted	Supporting documents	
		2021	2022			Purchase Order or Invoice	Delivery note
National Transfusion Safety Program	Transfusion safety inputs	2,217,525	2,217,525	2,217,525	-	-	OK
	Transfusion safety program	-	4,843,673.83	4,843,673,83	-	-	OK
Total		2,217,525	4,843,673.83	7,061,198.83	-	OK	OK

Source: MPHHP/* National Blood Transfusion Center*: 2021 to 2022 Public Funding for Transfusion Safety Inputs (October 31, 2022)

This table shows government spending directed towards purchasing blood transfusion inputs. They are included in the government's counterpart in the fight against HIV. They are included in the government's

counterpart in the fight against HIV and can be added in the accounting of total programmatic expenditures for the 3 diseases and HSS (WB loans + blood transfusion inputs) if information from 2018-2020 that can show the evolution since NFM2 and 2021-2022 is available.

Question 5.G: Program Essentials ***Indicate if any of the Program Essentials are currently not fulfilled, explain why, and describe the proposed pathway to reach them in coming years. (1/2 page)***

The Community-level IPTp, IPTi, SMC and the targeting and extension of the use of RDTs at the private sector level in 6 other cities are not implemented due to lack of funding at the level of NFM3. The same applies to the mobile community relay approach to increase coverage of cases among children in villages without health facilities.

1. Intermittent preventive therapy (IPT) - Pregnant women: Innovative EU initiatives currently under evaluation will be expanded to increase coverage. Communication will also be intensified to improve the age of pregnancy at the first consultation. UHC aims to increase access to the antenatal consultation service for pregnant women. Consideration could also be given to purchasing this indicator (World Bank project, DFID, USAID and the World Fund), in order to boost the IPT3.

2. Intermittent preventive therapy (IPTi) - infants: During NFM3, this intervention should be implemented in the first year in 3 Zones/Sentinel sites, then in the second year 2 additional sites, and an additional zone in 2023, i.e. a total of 6 sites under this grant and then gradually, it was envisaged to extend to the other 26 sentinel sites if the funds requested from the PAAR allowed, with additional resources from the Global Fund and other partners, we covered at least 80% of the eligible health areas (Vaccine coverage greater than 80%).

3. Seasonal Malaria Chemoprevention (SMC): The 4 southern provinces: Lualaba, Haut-Lomami, Haut-Katanga and Tanganyika, for climatic reasons and epidemiological trends are eligible for this intervention. With 3 health zones, the first year is 2 in Haut Katanga (1 urban and another rural) and 1 in Lualaba (rural). It will subsequently be conducted in two districts in 2022 and two in 2023.

4. The targeting and extension of the use of RDTs at the private sector level in 6 cities of the private sector project was not funded

These innovative interventions are part of the arsenal of efforts to combat malaria in Africa

DRC and feature prominently in the NSP 2024-2028. They are contributing to the growth of new tools to fight malaria. The Global Fund, together with the State and other partners, including the mobilization of local resources at the community level, is called upon to implement these interventions.

Section 6. Implementation

Question 6: Are changes needed to implementation arrangements? Yes or No? **(1/2 page)**

If the applicant responds "No" to this question, they only need to mark "No". **If "Yes", applicants should describe:**

☒ Yes ☐ No

If Yes: explain what these changes are, risks being addressed and expected improvements for the program. A

The institutional set-up for implementation envisaged by the CCM calls for the Ministry of Public Health, Hygiene and Prevention to continue as Principal Recipient.

As for civil society Principal Recipients, the CCM has opted to launch a transparent and inclusive process to select new Principal Recipients.

Accordingly, two calls for expressions of interest (CEIs) were launched on the national website www.mediacongo.net on February 23, 2023 and on the international website www.dgmarket.fr (https://www.dgmarket.com/tender/62874895/ https://www.dgmarket.com/tender/62874913) to recruit two civil society Principal Recipients to manage the Malaria and TB/HIV grants.

As the process is underway (the deadline for applications is March 29, 2023), the CCM will sit down to select the most qualified candidates. Thereafter, to ensure compliance and transparency of the process, the Local Fund Agent (LFA) will verify the management capacities of the selected Recipients.

The PRs will be responsible for recruiting SRs, under the coordination of the DRC CCM.

In addition, a logistics provider will be recruited by the Global Fund in collaboration with the CCM in accordance with current procurement procedures and international conventions. The logistics provider will be responsible for the management and supply of all drugs and inputs, including insecticide-treated nets, a task previously performed by the Principal Recipients of civil society.

In order to minimize the risks of fraud in the management of finances, it is necessary to ensure the digitization of supporting documents by training sub-recipients (DPS and civil society SRs) in Tom2Pro and the use of 0nedrive.

In relation to PSM (Procurement and Supply Management), stock-outs, overstocks and recorded expiries will be minimized by approving quantified needs for various products (specific drugs, reagents, medical equipment, LLINs, etc.) at the level of national programs and the CCM.

Annex 1: Documents Checklist

Use the list below to verify the completeness of your application package.
This checklist only applies to applicants requested to apply using the Program Continuation application approach.
Refer to the Program Continuation Instructions[2] for details, applicability and resources.

Documents Reviewed by the Technical Review Panel

☒	Funding Request Form
☒	Performance Framework
☒	Detailed Budget
☒	Programmatic Gap Table(s)
☒	Funding Landscape Table(s)
☒	Prioritized Above Allocation Request (PAAR)
☒	Health Product Management Template
☒	Implementation Arrangement Map(s)
☒	RSSH Gaps and Priorities Annex
☒	Gender Assessment (if available)
☒	Assessment of Human Rights-related Barriers to Services (if available)
☒	Essential Data Table(s)
☒	National Strategic Plans
☐	Innovative Financing Documentation (if applicable)
☐	Supporting Documentation Related to Sustainability and Transition (if available)
☒	List of Abbreviations and Annexes

Documents Assessed by the Global Fund Secretariat

☒	Funding Priorities from Civil Society and Communities Annex
☒	Country Dialogue Narrative
☒	CCM Endorsement of Funding Request
☒	CCM Statement of Compliance
☒	Additional documentation to support co-financing requirements
☒	Sexual Exploitation, Abuse and Harassment (SEAH) Risk Assessment (optional)

[2] Program Continuation Instructions - https://www.theglobalfund.org/media/7356/fundingrequest_programcontinuation_instructions_en.pdf