DEMOCRATIC REPUBLIC OF THE CONGO

FAMILY PLANNING

National Multisectoral Strategic Plan (2014 – 2020)

Acknowledgments

The adoption of the National Strategic Plan for Family Planning (FP) on January 10, 2014 by the General Secretary of the Ministry of Health, jointly with the different health divisions, programs and partners involved in Family Planning interventions, allows me to thank all those who have contributed to this plan's finalization and who have provided technical and financial support for its development.

I particularly thank the members of the Permanent Multisectoral Technical Committee for FP (CTMP), who have facilitated the completion of this plan, paving the way to fulfilling the resolutions adopted at the 2009 National Conference to Reposition Family Planning.

I am also grateful to all Provincial Ministers, Provincial Health Inspectors and Provincial Coordinating Doctors responsible for reproductive health for their valuable contribution to this document as they shared their field experience and knowledge of the FP needs expressed by women and couples in their respective provinces.

I also thank all technical staff from other ministries, as well as all technical and financial partners (TFP) who have spared no effort in assuring the finalization of this strategic plan. I am particularly grateful to the technical, financial and personal support of the participants of Advance Family Planning, ASD, ASF/PSI, C-Change, DKT, IRC, IRD, MSH, PARSS, PROSANI, PROVIC, Save The Children, the School of Medicine at the University of Kinshasa, the Kinshsa School of Public Health, Tulane University, UNFPA, USAID and WHO.

Moreover, I would like to express my profound gratitude to the participants of the Ministry of Public Health (DSSP, D10, PNSA, DEP) and other Ministries, as well as the civil society organizations and NGOs involved for their mobilization and commitment to finalize this plan under the PNSR's Direction. Among the participants involved are the Ministry of Gender, Family Affairs and Children; the Ministry of Plan and of Monitoring Implementation of the Revolution toward Modernity; as well as the Ministry of Social Affairs and National Solidarity; participants from Maman Ansar, UCPPF, Conduite de la Fécondité, ABEF-ND, and others.

To all of them, I am deeply grateful for the momentum they have created around the development this National Multisectoral Strategic Plan for Family Planning, which constitutes an essential component of the Revolution of Modernity as it acknowledges the right of Congolese women and couples to make free and informed choices regarding the timing and number of children they wish to have.

Dr MUKENGESHAYI KUPA

Secrétaire Général à la Santé

PREFACE
Letter from the Minister of Public Health

At the moment where our country is engaged in a revolution of modernity for a Congo emerging on the horizon in 2030, the revitalization of Family Planning, as stipulated in the second edition of the Growth and Poverty Reduction Strategy Document , is a major component in the acceleration of lasting socio-economic development. In matters of Family Planning, the Democratic Republic of Congo favors the choice of responsible parenting and planned births.

The Program of Action adopted by the participants of the International Conference on Population and Development held in Cairo in 1994, including the Republic of Zaire, now the Democratic Republic of Congo (DRC), defines in Chapter 7 the notion of "reproductive health rights" as follows:

"By reproductive health we mean the general physical, mental and social well-being of human beings, including their reproductive system, its functions and functioning, and not only the absence of disease or disability. This means that a person should be able to lead a satisfying sexual life without risk, and procreate as often or not as they wish. This last condition implies that men and women have the right to be informed and use the Family Planning method of their choice, or any other legal birth-control method of their choice; these methods must be safe, efficient, affordable and acceptable. Men and women also have the right to access health services that allow for safe pregnancy and safe birth delivery, giving couples the opportunity to have a healthy child."

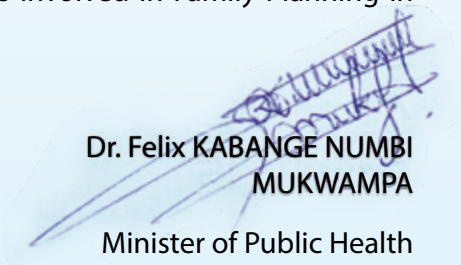
Family Planning, a component of reproductive health, is given special attention in Chapter 7, which underlines the multiple benefits of Family Planning use by men, women and families.

In all research reports conducted in the DRC from 1998 to 2010, the Family Planning situation has been troubling. Indeed, in 2010 only 5.4% of Congolese women living in union used a modern contraceptive method, one of the lowest rates in Africa. Congolese women have 6.3 children on average, two to three times more than in emerging countries.

Aware of this situation, the government of the Republic has implemented resolutions based on the recommendations of the 2nd National Conference to Reposition Family Planning held in Kinshasa in 2009, mainly through two follow-up mechanisms: the Political Advocacy Committee (CPP) and the Permanent Multisectoral Technical Committee (CTMP). It is from these committees, and their numerous meetings and hard work, that experts from the government and technical and financial partners were able to finalize the Multisectoral Strategic Plan for Family Planning, which I am proud to introduce today.

This strategic plan, adopted on January 10, 2014, covers the period from 2014-2020 and was designed as a reference tool for all Family Planning interventions in the Democratic Republic of Congo (DRC). It aligns with the National Health Development Plan (PNSD) 2011-2015, and will also contribute to governmental actions included in DSCRP II, which seeks to reduce poverty, improve social conditions for the Congolese people through decreasing population growth, and reduce maternal and child mortality, among other things.

I thank all experts from the government, as well as all the technical and financial partners who have contributed to the drafting and finalization of this National Multisectoral Strategic Plan for Family Planning, whose provisions will guide all actors and partners involved in Family Planning in the Democratic Republic of Congo (DRC).



Dr. Felix KABANGE NUMBI MUKWAMPA

Minister of Public Health

ACRONYMS

ABEF	:	Association de Bien-Être Familial *(Association for Family Well-Being)*
AFP	:	Advance Family Planning
ANIC	:	Association Nationale des Infirmiers du Congo *(Nurses Association of Congo)*
AS	:	Affaires Sociales *(Social Affairs)*
ASD	:	Action Santé et Developpement *(Association Health and Development)*
ASF	:	Association Santé Familiale *(Family Health Association)*
AZBEF	:	Association Zairoise de Bien Etre Familial *(Zairian Association for Family Well-Being)*
CAO	:	Cadre d'Accélération des Objectifs du Millénaire pour le Développement *(Road Map to accelerate the acheivement of Millinium Developmment Goal)*
CBD	:	Community-based distribution
CBO	:	Community-based organization *(Organization a Base Communautaire)*
C-CHANGE	:	Communication for Change
CHW	:	Community Health Worker
CNND	:	Comité National des Naissances Désirables *(National Committee for Desirable Births)*
CPP	:	Comité de Plaidoyer Politique *(Political Advocacy Committee)*
CTMP	:	Comité Technique Multisectoriel Permanent *(Permanent Multisectoral Technical Committee)*
CYP	:	Couple Year-Protection *(Annee Protection Couple –APC)*
D10	:	10th Health Division *(Family and Specific Groups)*
DEP	:	Direction d'Étude et de Planification *(Division of Study and Planning)*
DFID	:	Department for International Development
DHS	:	Demographic and Health Survey
DPS	:	Divisions provinciales de la santé *(Provincial Health Divisions)*
DRC	:	Democratic Republic of Congo
DSCRP I	:	Document de la Stratégie de Croissance et de Réduction de la Pauvreté de seconde génération *(Growth and Poverty Reduction Strategy Document, First generation)*
DSCRP II	:	Document de la Stratégie de Croissance et de Réduction de la Pauvreté de seconde génération *(Growth and Poverty Reduction Strategy Document, Second generation)*
DDSSP	:	Direction des Soins de Santé Primaires *(Primary Health Services Division)*
ELS	:	Etat de Lieux de la Sante *(Health Assessment status)*
ENI	:	
ESP	:	Ecole de Sante Publique de Kinshasa *(Kinshasa School of Public Health- KSPH)*
EPSP	:	Enseignement Primaire, Secondaire et Professionnel *(Primary, Secondary and Professional Teaching)*
FBO	:	Faith-Based Organizations
FEC	:	Fédération des Entreprises du Congo *(Congolese Federations of Business)*
FP	:	Family Planning
GAP	:	see page39 "Budgeting)
GDP	:	Gross Domestic Product
GFC	:	Gender, Family and Children
GIBS	:	Groupe Inter-Bailleurs de Santé *(Group of Health Donors)*
GRH	:	General Referral Hospital *(Hopital General de Reference-HGR)*
HC	:	Health Center *(Centre de Santé –CS)*
HEUSR	:	Higher Education, University and Scientific Research *(Enseignement Superieur, Universitaire et Recherche Scientifiques-ESURS)*
HF	:	Health Facility
HZ	:	Health Zone *(Zone de Sante-Z/S)*

IMA	:	Interchurch Medical Assistance
INS	:	Institut National des Statistiques *(National Statistics Institute)*
IPPF	:	International Planned Parenthood Federation
IRC	:	International Rescue Committee
IRD	:	Institut de Recherche pour le Développement *(Research Institute for Development)*
IUD	:	Intra Uterine Device *(Dispositif Intra Utérin –DIU)*
M&E	:	Monitoring and Evaluation
MDG AF	:	Acceleration Framework of the Millennium Development Goals
MICS	:	Multi Indicator Cluster Survey
MoH	:	Ministry of Health
MP	:	Minister of Province *(Ministre Provincial)*
MSH	:	Management Sciences for Health
NFP	:	Natural Family Planning
NGO	:	Non Governmental Organization *(Organisation Non Gouvernementale-ONG)*
PARSS	:	Programme d'Appui à la Réhabilitation du Secteur de la Santé *(Health Sector Rehabilitation Support Project)*
PCA	:	Paquet Complémentaire d'Activités *(Package of Complementary Activities)*
PESS	:	Projet d'Équipement des Structures Sanitaires *(Health Facilities Equipment Project)*
PMA	:	Paquet Minimum d'Activités *(Minimum Package of Activities)*
PMA 2020	:	Performance Monitoring and Accountability 2020
PMTCT	:	Preventing Mother To Child Transmission *(Prévention de la Transmission Mère et Enfant du VIH/SIDA-PTME)*
PNAM	:	Programme national d'approvisionnement en médicaments *(National Medical Supply Program)*
PNC	:	Prenatal Consultation *(Consultation Pre Natal-CPN)*
PNDS	:	Plan National de Développement Sanitaire *(National Health Development Plan)*
PNSA	:	Programme National de Santé des Adolescents *(National Program for the Health of Youth)*
PNSR	:	Programme National de Santé de la Reproduction *(National Program for Reproductive Health)*
PNC	:	Postnatal Consultation *(Consultation Post Natale-CPON)*
PPDS	:	Plan Provincial de Développement Sanitaire *(Provincial Health Development Plan)*
PROSANI	:	Projet de Santé Intégré *(Integrated Health Project)*
PROVIC	:	Projet de VIH/SIDA Intégré au Congo *(Integrated HIV/AIDS Project in Congo)*
PSC	:	Preschool Consultation *(Consultation Pré-Scolaire-CPS)*
PSI	:	Population Service International
PSND	:	Projet des Services de Naissances Déesirables *(Project for Desirable Births Services)*
REDD+	:	Reducing emissions from deforestation and forest degradation
RH	:	Reproductive Health
SA	:	Social Affairs *(Affaires Sociales-AS)*
SCEV	:	Services d'Éducation à la Vie *(Life Education Services)*
SCOGO	:	Société Congolaise de Gynécologie et d'Obstétrique *(Congolese Society of Gynecology and Obstetrics)*
SDP	:	Service Delivery Point
SNIS	:	Système National d'Information Sanitaire *(National Health Information System)*
SPH	:	School of Public Health
SSP	:	Soins de Santé Primaires *(Primary Health Care)*
TFP	:	Technical and Financial Partners
UCPPF	:	Union Congolaise des Prestataires en Planification Familiale *(Congolese Union of Family Planning Providers)*
UN MDG	:	United Millennium Development Goal *(Objectif du Millénaire pour le Développement-OMD)*
UNAAC	:	Union Nationale des Aides Accoucheurs du Congo *(National Union of Birth Attendants in Congo)*
UND	:	Unité des Naissances Désirables *(Desirable Births Services)*
UNFPA	:	United Nations Population Fund
UNICEF	:	The United Nations Children's Fund
USAID	:	United States Agency for International Development
WHO	:	World Health Organization

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SUMMARY
Strategic Plan for Family Planning : 2014-2020

The Democratic Republic of Congo (DRC) is a vast country with great natural resources. The government faces important challenges to provide communities with social infrastructure and services in general (such as schools, housing, roads, and food), as well as primary health services in particular to its population of 68 to 80 million.

Because of high maternal mortality and rapid demographic growth, the government identified Family Planning as one of the six priority interventions in its plan to accelerate progress towards the achievement of the 4th and 5th Millennium Development Goals. Recent studies have shown that the fertility rate of the DRC is at 6.3%, while a quarter of married women in the DRC population wish to avoid pregnancy but do not use any contraceptive. This strategic plan, developed over the course of a 12-month period through a participatory process involving various actors and sectors, provides a roadmap to increase modern contraceptive prevalence from its current rate of 6.5% to 19.0% by 2020. This objective is now easier to meet as more than 80% of all men and women in the DRC know of at least one contraceptive method.

Current access to Family Planning services is limited, particularly in rural areas. Less than half (46%) of the country's 516 health zones offer Family Planning services. Furthermore, although part of the services offered in the Minimum Package of Activities (PMA), Family Planning is often neglected. However, in 2012 the Ministry of Public Health took concrete measures to strengthen Family Planning by allocating funding to procure contraceptives, equipment and health supplies for 66 health zones. In addition, a bill was introduced to support Family Planning from a legal standpoint.

The National Strategic Plan for Family Planning 2014-2020 has two objectives:

1. Increase modern contraceptive prevalence, estimated at 6.5% in 2013, to at least 19.0% by 2020; and
2. Ensure access to and use of modern contraceptive methods to at least 2.1 million additional women by 2020.

The implementation of the plan involves six sub-objectives:

1. Obtain the effective and concrete commitment of the government to support Family Planning;
2. Improve access for men and women to Family Planning services in the public and private sectors;
3. Increase the quality of Family Planning services;
4. Generate demand for Family Planning;
5. Develop and strengthen an efficient logistical system to manage contraceptives; and
6. Implement a reliable evaluation system to measure results.

The success of implementation will require active participation from several actors, including:

- The government of the DRC through its different ministries, including the Ministry of Public Health (PNSR and PNSA); Ministry of Gender, Women and Children; Ministry of National Education; Ministry of Higher Education, University and Scientific Research; Ministry of Social Affairs; Ministry of the Environment; Ministry of Labor and Social Welfare, etc.
- Non governmental organizations (national and international)
- Faith-based organizations (Catholic, Protestant, the Salvation Army, Kimbanguist, Muslim, Evangelical).
- National and international donors
- Civil society
- Commercial entities from the private sector (corporations, for-profit organizations).

This strategic plan includes the cost of all proposed activities for the six sub-objectives. The total cost for the entire 2014-2020 period is estimated at $240 million (U.S.); of this total, $54 million are needed to purchase contraceptive products and $90 million to support service delivery. A table listing the costs by year and by type of cost (contraceptive commodities, personnel, overhead, and support to FP programs) is presented in the plan.

The success of this ambitious plan will be measured in terms of progress made towards the first two objectives: a modern contraceptive prevalence rate of 19% throughout the country; and at least 2.1 million additional contraceptive users by 2020. Throughout this period, results will be monitored continuously in terms of the six sub-objectives (government commitment, access, quality, demand creation, contraceptive logistics, and M&E), based on indicators described in the document.

FOREWORD

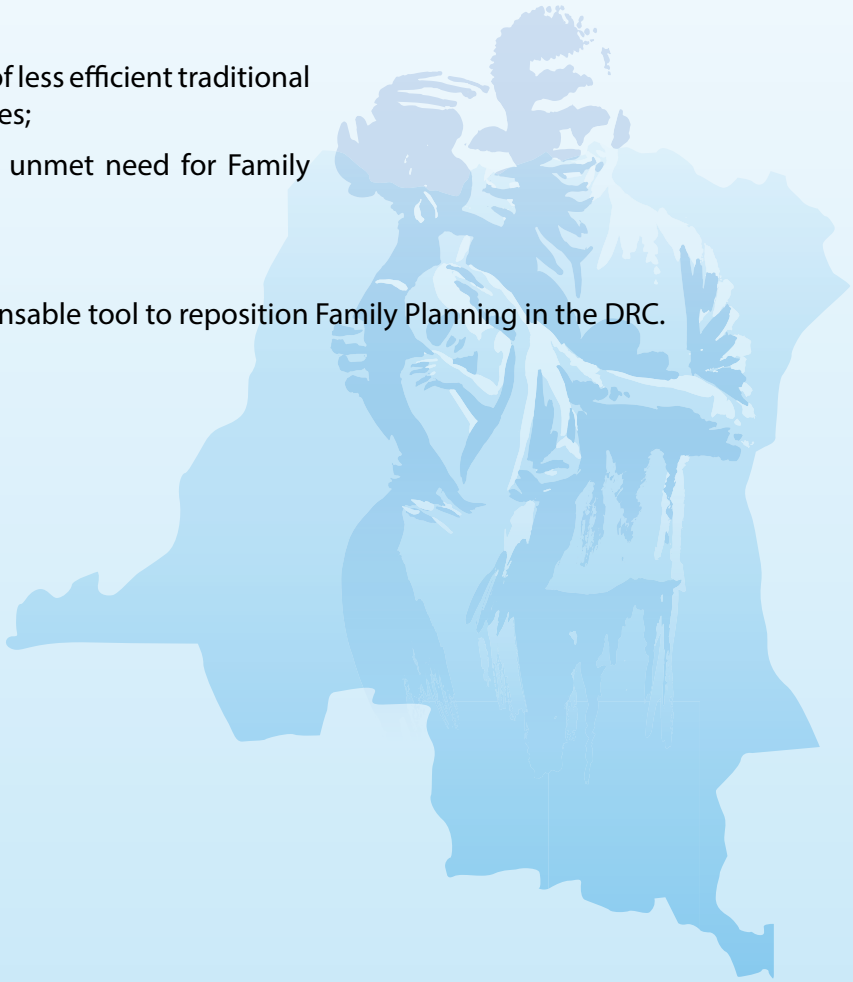
This National Strategic Plan for Family Planning aligns with the implementation plan of the National Health Development Plan (PNDS) 2011-2015. By reducing high-risk pregnancies, it will contribute to the government's efforts to reduce maternal and child mortality.

As the PNDS will soon come to its end date, the present plan covers the period of 2014-2020. It was designed as a reference tool for all Family Planning interventions in the Democratic Republic of Congo (DRC).

Its implementation will:

- Ensure a sustained increase in modern contraceptive use by Congolese women and men who wish to use contraception;
- Progressively decrease the use of less efficient traditional methods in favor of modern ones;
- Respond to the currently high unmet need for Family Planning

This National Strategic Plan is an indispensable tool to reposition Family Planning in the DRC.



1 INTRODUCTION

The Democratic Republic of Congo (DRC) is a vast country with great natural resources. During the previous two decades the country has faced numerous crises that have affected all aspects of its social, economic and political development. As a result, the DRC ranks among the countries with the lowest health and development indicators despite the progress made in the past few years. As a result, the DRC faces numerous challenges in nearly all sectors.

Among these numerous challenges to address, this strategic plan focuses on the importance of increasing contraceptive use in the DRC. This increase will not only contribute to the improvement of maternal and child health in the country, but by also controlling rapid population growth thus accelerating improvement of living conditions for the Congolese population.

1.1. Demographic Situation

In 2013, the DRC's population was estimated at 68 million inhabitants by the United Nations Population Division, and at 80 million by the National Institute of Statistics. In 2010, the country's total fertility rate was estimated at 6.3 children per woman, the child mortality rate (children under 5 years old) at 158/1000 living births[1] and the ratio of maternal mortality in 2011 at 540/100,000 living births[2]. Despite these still high mortality rates, the prevailing high fertility rate in the country has led to an annual population growth of 2.8% or an increase of 2 million people per year, with the population doubling every 25 years. This annual increase will continue to accelerate and sustain itself as a result of a growing number of young women entering their reproductive period. Such a phenomenon, known as the population momentum, is unavoidable, as the mothers of tomorrow have already been born.

With 45% of its inhabitants under the age of 15 and only 3% over 65, the DRC has a very young population. This large proportion of young people has significant consequences on the socio-economic development of the country. These youth must be cared for by their parents, but also by public health and education services.

The increase in modern contraceptive use, which is object of this plan, should allow for the progressive slowing of demographic growth, which in turn, will result in a lower burden on the economically active population between 15 and 64. In other countries, this reduction has enabled an increase in savings and investments that has stimulated development. The DRC could learn from the experience of these countries to follow a similar path and benefit from what has been called the "demographic dividend."

In the DRC, nearly 80% of pregnancies among women married or in union can be classified as "at risk," as they are likely to be "too early, too close, too numerous, or too late." In most cases, pregnancies have several of these risk factors. In 2013, about 1.7 million pregnancies out of approximately 3 million were potentially at risk, while 800,000 of these pregnancies were

1 MICS RDC 2010

2 World Bank 2013, World Development Indicators, http://databank.worldbank.org/data/views/variableSelection/selectvariables.aspx?source=world-development-indicators

considered high-risk. These women need extra attention during the pregnancy itself, during childbirth, and post-partum, when extra attention should be paid to the newborn. Unfortunately, many families living in poverty cannot afford the costs associated to these services, which exposes them to higher maternal and child mortality risk, as well as malnutrition in their young children. The number of children that Congolese women wish to have remained at 5.6 children in 2007, which is lower than the observed fertility rate of 6.3 children per woman.

1.2. Current Family Planning Situation

According to the results of the MICS survey conducted in the DRC in 2010, the modern contraceptive prevalence rate was 5.4%, which remains low compared to many African countries. However, 24% of Congolese women expressed an unmet need for Family Planning, meaning that they wanted to space their births, or to not have any more children, but were not using any contraceptive method to prevent unwanted pregnancies.

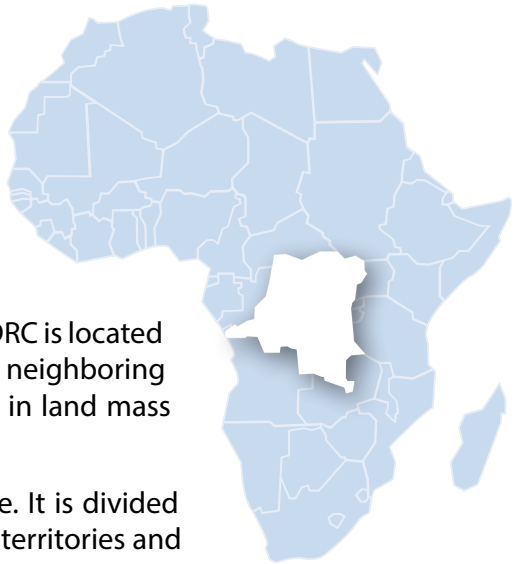
Aware of this situation, the government of the DRC decided to make Family Planning a national priority. This decision would allow for a transition from unwanted and unplanned births to desired and planned ones. In doing so, the country would undergo a "contraceptive revolution" thanks to the widespread use of Family Planning services.

1.3. The Reason for a Strategic Plan

To implement its vision on Family Planning, the government of the DRC, through the Ministry of Public Health, took the initiative to develop a National Strategic Plan for 2014-2020 that is within the framework of initiatives to reduce maternal and child mortality in order to contribute to the well-being of women, families and the entire community.

The implementation of the activities described in this plan includes participation from actors at different levels (national, provincial, local). It also requires a multisectoral approach with cooperative efforts from several ministries and donors, national and international non-governmental organizations (NGOs), and faith-based organizations (FBOs). These efforts will be coordinated by the National Program for Reproductive Health (PNSR), the structure mandated by the Ministry of Public Health to promote and coordinate activities related to reproductive health.

2 GENERAL CONTEXT OF THE DRC



2.1. Geographic, political and administrative context

With a total area of 2,345,409 square kilometers, the DRC is located in Central Africa and shares 9,165 km of border with nine neighboring countries. The DRC is the second largest country in Africa in land mass after Algeria.

The DRC is a unified but strongly decentralized state. It is divided into 11 provinces, 25 districts, 21 cities, 145 administrative territories and 77 communes. The Constitution of the Third Republic (February 2006) includes a transition from 11 to 26 provinces and eliminates the level of district jurisdiction.

2.2. Socio-economic and health situation

With regard to human development, the DRC is characterized by widespread poverty, estimated at 71% in 2005, which contrasts markedly with the country's enormous economic potential.

As of 2005, seven in ten households were living in poverty nationwide, with significant disparities between rural and urban areas. In rural areas eight in ten households were poor, while in urban areas less than seven in ten households were living in poverty. This contrast also exists at the provincial level. Food represented 62.3% of total household expenditure in 2005. The scope of poverty also varies depending on type of occupation (independent workers and apprentices in the informal sector are the most disadvantaged.

With regard to the economic situation, the growth rate of the GDP has showed marked fluctuations since independence in 1960. In 2010, 2011 and 2012, the average growth rate was 7%. However, because of population growth, the increase of the GDP per capita was only of 4%, which remains insufficient to rapidly reduce poverty in the country.

Regarding health status, progress has been made in the past ten years, particularly in reducing maternal mortality. Table 1 below shows the situation of maternal mortality in the DRC as well as key indicators of Family Planning.

Tableau 1. Key health and Family Planning indicators: 1995 to 2010

Source	Maternal mortality ratio	Modern contraceptive prevalence	Unmet need	Total fertility rate	Adolescent fertility rate
1st ELS 1998	1837/100.000	4,6	-	7,2	-
MICS 2001	1289/100.000	4,4	-	7,1	20,0
DHS 2007	549/100.000	5,8	24,0	6,3	19,0
MICS 2010	-	5,4	24,0	-	13,5

According to the data presented in Table 1, modern contraceptive prevalence has virtually stagnated in the past ten years, between 4.4% and 5.8%. Unmet needs for Family Planning also remained at 24% between 2007 and 2010. The total fertility rate slightly decreased from 7.2 in 1998 to 6.3 children per woman in 2007. Meanwhile, the fertility rate of adolescents significantly decreased from 20 per 1000 women 15-19 in 2001 to 13.5 per 1000 women 15-19 in 2010.

Figure 1. Map of the DRC

The government's response to reduce poverty and maternal mortality is outlined in the Growth and Poverty Reduction Strategy Document, Second Generation (DSCRP II 2011-2015). Among other objectives, this document seeks to improve the population's access to basic social services, including health and Family Planning.

2.3. Demographic situation

According to the 1984 Census, the DRC's population was 29 million, more than twice its population of 1958, when it was 13.5 million. In mid-2013, the national population was estimated at 80 million by the National Institute of Statistics (INS), at 68 million by the United Nations Population Division, and at 69 million by SPECTRUM in relation to a project on the demographic dividend supported by the PARSS project (Health Sector Rehabilitation Support Project).

The demographic growth rate of the DRC was estimated at 3.4% in 2013 by the INS, at 2.7% by the United Nations, and at 2.9% by SPECTRUM. In spite of these differences, all estimates currently available indicate that the population of the DRC will reach 100 million inhabitants around 2030. The results of the next Census in 2015 will refine these estimations.

Table 2 below shows projections for the total population, as well as the female population who are of reproductive age in the DRC through 2030.

Tableau 2. Projected population for the DRC from 2010 to 2030

Years	SPECTRUM Projections (August 2013)			United Nations Projections (june 2013)		
	Total population (in millions)	Women aged 15-49 (in millions)	% total population	Total population (in millions)	Women aged 15-49 (in millions)	% total population
2010	62,2	14,1	22,7	62,2	14,1	22,7
2013	67,9	15,5	22,8	67,5	15,5	22,9
2020	82,8	19,2	23,2	81,3	19,2	23,7
2025	94,4	22,3	23,6	92,1	22,3	24,2
2030	106,9	25,9	24,3	103,7	25,7	24,7

Sources : *Calculations with Spectrum: Guengant Report on Quantification and Cost of the National Strategic Plan for Family Planning – United Nations, 2013.*[3]

The strong demographic growth projected for the coming years is the result of a continuing high fertility rate and a young population (the mothers of tomorrow – themselves from large families – have already been born).

According to the results of the 2010 MICS survey, the fertility rate was of 6.3 children per woman. However there were disparities between women from high-income and low-income households, as well as between educated women and women who did not attend school. Adolescents (15-19 years old) significantly contribute to the fertility rate.

The capital city of the DRC, Kinshasa, has a rapidly growing population and has increased from 1.5 million inhabitants in 1975 to over 10 million in 2013. According to the INS, 67% of the Congolese population was living in rural areas in 2013 (65% according to the United Nations[4]).

3 United Nations 2013-Population Division, World Population Prospects: The 2012 Revision, http://esa.un.org/unpd/wpp/index.htm, released June 13, 2013

4 United nations 2012, United Nations. (2011). World Urbanization Prospects: The 2010 Revision. New York, NY: United Nations, Department of Economic and Social Affairs, Population Division http://www.un.org/esa/population

2.4. Health system and policy development

The Ministry of Public Health comprises three levels (central, provincial and operational), each of which plays a defined role in accelerating the reduction of maternal and child mortality. The central level plays a normative role, regulating and supporting the provinces (Provincial Health Divisions).

Each of the 11 provinces has a provincial ministry of health (DPS) with its own health division.. In 2012, a ministerial ordinance increased the number of DPS to 26, and the process is underway to put them in place. .

At the operational level, the country is divided into 516 health zones (HZ), 424 of which have a General Referral Hospital (GRH) or equivalent structure. Each HZ is divided into a series of health areas. Throughout the country there are 8,504 health areas but only 8,266 are served by a Health Center (HC). Nearly 7,500 offer maternal care, but less than half of them provide Family Planning services.

The DRC adopted the **primary health care** ((PHC)) strategy in 1981, which includes Family Planning among the eleven components of the Minimum Package of Activities (PMA) to be offered at primary health facilities, as well as in the Complementary Package of Activities (PCA) delivered in referral health facilities. The content of these packages was defined by the Ministry of Public Health, and Family Planning is one of the essential components.

To conduct Family Planning activities, the government works through the Ministry of Public Health and its National Program for Reproductive Health (PNSR). This program is responsible for developing policies and norms on Family Planning, and to coordinate with donors that support FP activities.With national and international NGOs, the PNSR shares responsibility for implementing FP activities. Of note, more than 90% of Family Planning services are supported by the government's partners (donors and implementing partners). Since the country has committed to reposition Family Planning, both the Ministry of Gender, Family Affairs and Children, and the Ministry of Planning have been involved in coordinating FP activities consistent with their own mandates.

3 FAMILY PLANNING PROGRAM IN THE DRC AND PRIORITY ISSUES

3.1. Family Planning History

The DRC's Family Planning program is based on an approach that favors responsible parenthood and desirable births, a concept that appears in the Constitution, specifically in its 45th, 47th, 48th and 49th articles, and was also used for this first time in 1972 by President Mobutu in a speech to the nation. The concept of desirable births is part of a larger effort to enable couples to manage their fertility and prevent unwanted pregnancies, in an effort to combat clandestine abortions.

As a Belgian colony until 30 June 1960, the DRC inherited the colonial law of 1920 which forbade the sale and distribution of contraceptives. However in 1972, President Mobutu, in a speech to the nation, authorized the provision of Family Planning services, and introduced by presidential ordinance the concept of Desirable Births (Naissances Désirables).

1973	The President signs a presidential decree authorizing Family Planning activities, in spite of the colonial law of 1920 that was renewed in 1967 as the 448th Article of the Penal Code.
1976	Implementation of the Desirable Birth activities is entrusted to the Committee for Desirable Births (CNND). Catholic institutions also joined the movement during the same year.
1978	The CNND becomes an affiliated member of the International Planned Parenthood Federation (IPPF). The Committee becomes an NGO and is renamed the Association Zaïroise de Bien-Être Familial (Zairian Association of Family Well-Being).
1982	The Ministry of Health creates the Desirable Births Services Project (Programme des Services de Naissances Désirables, PSND). During the same year, the Catholic Church demonstrates its support to Family Planning by creating a Natural Family Planning (NFP) service.

1972-1990	The DRC makes significant progress in Family Planning with essential support from its partners. Unfortunately, these achievements are obliterated by the numerous socio-political crises that in 1991 bring a sudden and complete halt to international cooperation. A series of studies conducted in country show that throughout the history of the DRC, modern contraceptive prevalence at the national level has never exceeded 6%. Modern contraceptive prevalence has been documented in different studies as follows: 1.5% (EPC-Zaire) in 1984; 4.6% in 1998; 4.4% (MICS2) in 2011; 5.8% (DHS 2007) in 2007; and 5.4% (MICS 2010) in 2010.
1996	The PSND is transformed into the National Program of Desirable Births (Programme National de Naissances Désirables, PNND); in 2001 it becomes the National Program for Reproductive Health (Programme National de la Santé de la Reproduction, PNSR) and is tasked with: Elaborating, disseminating and promoting the national policy on Family Planning, as well as its guiding principles, organizational framework and reproductive health norms among the Congolese population and all FP partners; Coordinating, supervising, monitoring and evaluating all reproductive health activities ensuring the use of data collection tools authorized by the Ministry of Public Health; Mobilizing resources to support maternal care and Family Planning service delivery, providing ob-gyn equipment, essential medicines and contraceptives, and improving the quality of care and training of personnel, as well as promoting reproductive health research.
2004	The DRC organizes its First National Conference to Reposition Family Planning.
2009	The DRC organizes its Second National Conference to Reposition Family Planning.

3.2. Governmental efforts to support Family Planning

Although progress has been made regarding the health situation in the DRC, the level of performance on most health indicators remains below the average of Sub-Saharan African countries.

However, the government's efforts to advance Family Planning are visible at different levels:

1. The government's political commitment translated into the integration of Family Planning into DSCRP I and II. In its 3rd strategic pillar, DSCRP II highlights the necessity and urgency of revitalized Family Planning as a governmental priority in order to contain rapid population growth and ensure maternal and neonatal health and well-being.

2. In the National Policy for Reproductive Health (RH), reviewed in 2008, FP was identified as the second of nine components of RH. The national RH policy also seeks to implement affordable, acceptable, accessible and quality FP services at all times in both urban and rural areas.

3. Three years before the date targeted by the UN Millennium Development Goals (MDG), the DRC realized it had made slow progress and would not be able to achieve the 4th and 5th MDGs by that date. Therefore, the country decided to adopt an innovative new model called the Acceleration Framework of the Millennium Development Goals (MDG AF) aimed at hastening progress towards meeting the 4th and 5th MDGs. This framework includes Family Planning as one of its six priorities:

   a. Management of infectious diseases (malaria, pneumonia, diarrhea)
   b. Nutrition
   c. Neonatal and obstetrical care
   d. Family Planning
   e. Vaccination
   f. Water, hygiene and sanitation

Given the potential impact of Family Planning could have on the reduction of maternal and child mortality, the government of the DRC has identified it as a priority intervention to be scaled in all 516 health zones.

4. After the Second National Conference to Reposition Family Planning in 2009, several problems were identified, leading to the elaboration of priority recommendations outlined in Box 1.

5. Following up on the recommendations of the National Conference to Reposition Family Planning, a multisectoral committee was created to promote investment in Family Planning and monitor the implementation of said recommendations. This committee is composed of the Ministry of Public Health; Ministry of Gender, Family Affairs and Children; Ministry of Planning; as well as national and international NGOs, donors and FBOs.
6. Since 2012, the Congolese government has allocated a budget line for Family Planning activities, including the purchase of contraceptives as well as supplies and health equipment.
7. In 2013, for the first time in the history of the DRC, the government committed to use government funds to finance Family Planning activities in 200 health zones, including the purchase of contraceptives, as part of the Health Facilities Equipment Project (PESS). The project aims to specifically support the implementation of FP services in 200 GRH and 1,000 HC at a total spending of over $1 million (U.S.). Additionally, the government committed to maintain its efforts to invest more in Family Planning and ultimately deliver Family Planning activities in all 516 health zones in the country.
8. In terms of the Family Planning legislation, a RH/FP law was drafted in 2012 that would authorize Family Planning activities and repeal the law of 1920; it is currently under review in Parliament.

Box 1.
Key recommendations of the 2009 conference

1. Develop an official declaration to support Family Planning and repeal the law that prohibits Family Planning in the DRC;
2. Draft and pass a bill in favor of Family Planning;
3. Establish Family Planning as a priority issue on the government's agenda;
4. Allocate a budget line for Family Planning;
5. Ensure contraceptive security;
6. Establish a Permanent Multisectoral Technical Committee (CTMP) and a Political Advocacy Committee (CPP) to implement the recommendations of the National Conference.
7. Others

3.3. Health coverage and quality of Family Planning services

3.3.1. Health coverage of Family Planning services

Recent studies[5] have shown the weak integration of Family Planning services in most health zones. In total, 46% of the health zones included in the PMTCT survey (215 out of 473 HZ in all provinces but Kinshasa) offer FP as part of integrated health services.

In the 10 surveyed provinces, FP services are more available in urban (15%) than rural areas (4%). By comparison, all health zones in the city of Kinshasa[6] offer FP services, although their coverage is very unequal, ranging from 20% to more than 60% of facilities reporting to have FP activities.

The integration of Family Planning in new health projects (DFID, PARSS/World Bank, health zones receiving funding from government or other sources) could increase the number of health zones that offer integrated FP activities to 415 by 2014, although coverage of all areas (aires de santé) within these zones is not guaranteed.

To date, community-based distribution (CBD) of Family Planning methods has been initiated in selected health zones, but on a very small scale and mainly by non-governmental organizations and community associations (ABEF, Conduite de la Fécondité, and the Association of Muslim Women). The PROSANI Project, Pathfinder and other organizations have conducted similar implementations of CBD, although on a very limited basis.

Tableau 3. Health Zones with FP services by province (UNICEF-funded PMTCT Survey)

Province	Number of Health Zones	Number of Health Zones with FP	Proportion (%)
Bandundu	52	13	25,0
Bas Congo	31	10	32,0
Equateur	69	40	58,0
Kasai Occidental	44	10	23,0
Kasai Oriental	51	24	47,0
Katanga	67	46	69,0
Kinshasa	35		
Maniema	18	9	50,0
Nord-Kivu	24	10	42,0
Province Orientale	83	21	25,0
Sud-Kivu	34	32	94,0
Total	473	215	46,0

Coverage and implementation of community-based distribution in health zones are generally low; according to the 2007 DHS survey, only 4% of women not using contraception were visited by a CHW to discuss Family Planning.

5 Cartographies des interventions et intervenants en PF et de PTME réalisées en 2011 et 2012

6 Cartographie des services de PF à Kinshasa par Université de Tulane et l'Ecole de Sante Publique de Kinshasa réalisée en Déc. 2012

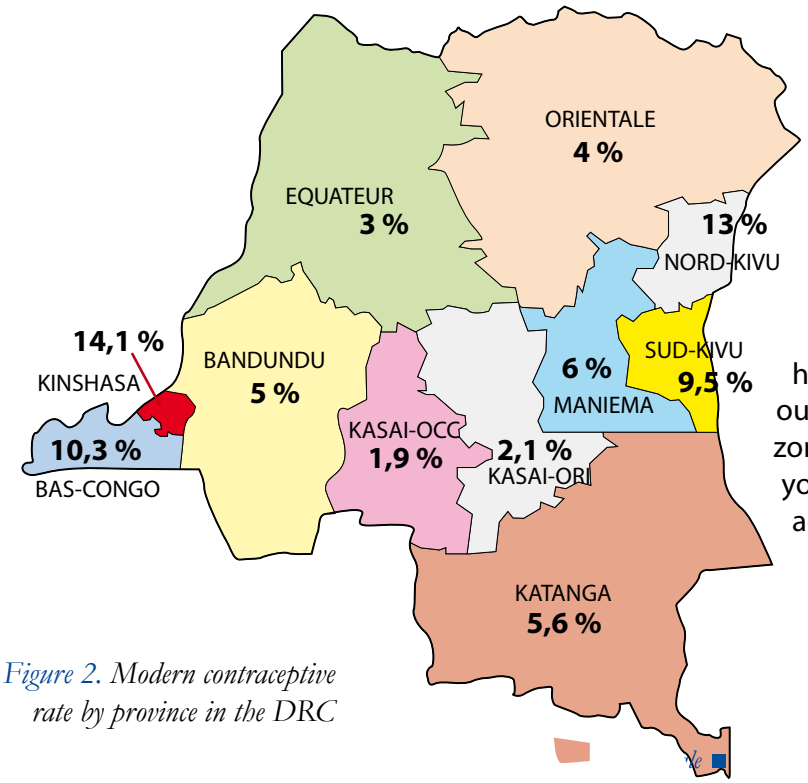


Figure 2. Modern contraceptive rate by province in the DRC

In the current national health system, adolescents and young people – who represent 32.8% of the population – do not receive the health services they need to address their general or specific SRH needs. Only 12 health zones (60 health facilities) out of the country's 516 health zones actually offer a package of youth-friendly reproductive health activities..

3.3.2. Quality of Family Planning services

An unpublished survey conducted by the National Program of Medical Supplies (PNAM) in 2011 showed that 81% of health facilities had had a contraceptive stock out over the 6-month period preceding the survey. Moreover, the PMTCT survey of 2012 showed that only 6% of health facilities in the 215 HZs offered at least three modern contraceptive methods.

In Kinshasa, another unpublished study led by Tulane University and Kinshasa University's School of Public Health in 2012 showed that only 18% of health facilities and pharmacies offered at least three Family Planning methods; only 13% had trained FP workers.

In general, FP services are lacking in the necessary equipment and materials to be operational. Even when FP services are offered, confidentiality is rarely guaranteed.

According to the 2007 DHS, 49% of women were not informed regarding the side effects of contraceptives, and 55% were not informed regarding the management of side effects.

According to the 2012 PMTCT maps (Table 4), approximately 28% of the country's health facilities (HC and GRH) have trained health workers to administer FP services. The Province Orientale has the lowest rate of trained workers (6.8%) whereas the Province of Nord-Kivu has the highest (over 60%).

Most FP projects are short-term and do not usually have exit strategies. Referrals from a health center to a general referral hospital are very rarely reported. Supervision is infrequent and often based on a review of documents only.

Tableau 4. Distribution of trained health providers by province, area of residence (urban or rural) and type of health facility (UNICEF-funded PMTCT Survey)

Trained health providers	HC (Health Center)		RHC (Referral Health Center)		GRH (General Referral Hospital)		Total	
	%	Count	%	Count	%	Count	%	Count
PROVINCES								
Kinshasa	52.6	216	47,7	44	65,4	26	52.8	286
Bas-Congo	22,8	281	16,9	83	51,6	31	23,8	395
Bandundu	15,2	946	22,5	142	55,0	40	17,6	1128
Equateur	14,5	838	29,9	77	35,3	51	16,8	966
Province-OR	6,1	1041	8,5	130	17,5	57	6,9	1228
Sud-Kivu	37,4	454	62,6	107	67,7	31	43,6	592
Maniema	44,1	195	50,9	53	57,9	19	46,4	267
Nord-Kivu	59,7	407	63,8	69	60,0	20	60,3	496
Katanga	34,4	687	43,6	78	48,6	37	36,0	802
Kasai-Occidental	28,4	433	26,8	82	26,1	23	28,1	538
Kasai-Oriental	32,1	742	42,0	88	40,0	45	33,5	875
Total	25,6	6240	34,8	953	44,5	380	27,8	7573
AREA								
Urban	39,3	952	47,0	151	63,4	95	40,7	1198
Rural	23,5	5288	32,5	802	38,2	285	25,3	6375
Total	25,6	6240	34,8	953	44,5	380	27,8	7573

3.4. Information system of Family Planning activities

The information system for FP activities is generally not efficient. Data on FP are collected at the health facility level but often are not transmitted to the health zone teams; even less frequently are they transmitted to the district and province levels and virtually never to the national level. In addition, the data sent to each level are incomplete and often cannot be used. Several factors explain this situation, including: the lack of a harmonized system at the central level, resulting in a multitude of data collection tools used by health facilities and partners; limited availability of some data collection tools; and the absence of a mechanism to share information.

The Health Information System is often incomplete as it lacks data on Family Planning, particularly on users and contraceptive uptake, as the data are often not available at the provincial level and even less so at the national level.

3.5. Funding of Family Planning

Financing for Family Planning is insufficient. Funding is mainly provided by international donors, such as USAID and UNFPA. In terms of FP funding, bilateral and multilateral donors contribute 85%, households 15% and the central government less than 1%. It is widely acknowledged that Family Planning activities have traditionally been funded by USAID, UNFPA and the IPPF.

Since 2011, other partners have joined the group of FP donors to finance Family Planning interventions, including DFID, the Global Fund, and the World Bank. As mentioned previously, starting in 2012, the government of the DRC committed to allocating funding to procure contraceptive products for certain health zones.

Tableau 5. History of spending (in USD) for contraceptive products from 2003 to 2012 from, by source of funding

Année	USAID	UNFPA	IPPF	The Global Fund	Netherlands, UN, PSI, autres	Total
2003	$ 2,062,785		$ 17,150			$ 2,079,935
2004	$ 4,821,136	$ 142,986	$ 50,478			$ 5,014,600
2005	$ 2,005,733	$ 74,119	$ 62,416			$ 2,142,268
2006	$ 636,316	$ 1,008,243	$ 48,882			$ 1,693,441
2007	$ 357,404	$ 1,904,727	$ 65,736			$ 2,327,867
2008	$ 1,056,698	$ 182,966	$ 75,044	$ 78,650		$ 1,393,358
2009	$ 2,693,294	$ 2,518,659	$ 42,673	$4,591,149	$ 213,282	$ 10,059,057
2010	$ 3,545,036	$ 1,626,070	$ 72,747	$ 953,381	$ 139,024	$ 6,336,258
2011	$ 5,860,439	$ 915,654				$ 6,776,093
2012	$ 8,567,791	$ 3,961,035			$ 178,478	$ 12,707,304
TOTAL 2003-12	$ 31,606,632	$12,334,459	$ 435,126	$ 5,623,180	$ 530,784	$ 50,530,181

***Source** : Reproductive Health Supplies Coalition , http://rhi.rhsupplies.org/*

L'historique des financements pour l'achat des contraceptifs a été retracé à partir de données du tableau de la Reproductive Health Supplies Coalition.

3.6. Human resources & continuing training

FP service delivery is mainly provided by nurses with various levels of certification and training, who generally form part of the medical staff working in health facilities. Doctors tend to be less interested or involved in Family Planning activities.

Although FP was adopted as part of the nine components of reproductive health in the DRC, its weak integration in the minimum and complementary activities packages (PMA and PCA) has led to a lack of interest among most households and health professionals. Very little time is devoted to Family Planning in the training curricula offered by medical and nursing schools, or universities.

Although Family Planning is included in the curriculum of secondary schools and training materials for secondary school teachers, Family Planning is not regularly taught in secondary schools.

The low status of women in the DRC influences their attitudes and behaviors. Article 144 of the Family Code states that women should obey and respect their husbands, which generally translates into a lack of dialogue in the household, particularly regarding sex (considered a taboo subject), the number of children to have, and their spacing.

Reproductive health services are generally directed at women rather than men (a feminization of FP services). The probability that a man is exposed to FP messages is limited, as compared to women who receive these messages during prenatal and postnatal consultations

The need to obtain the husband's authorization to use contraception also remains a major barrier to FP use among married women in the DRC.

Service delivery of contraceptive methods is still sporadic as it is not available on a daily basis. Some health facilities have office hours that do not favor FP promotion. In some health structures offering FP services, contraceptive methods are only offered once or twice a week.

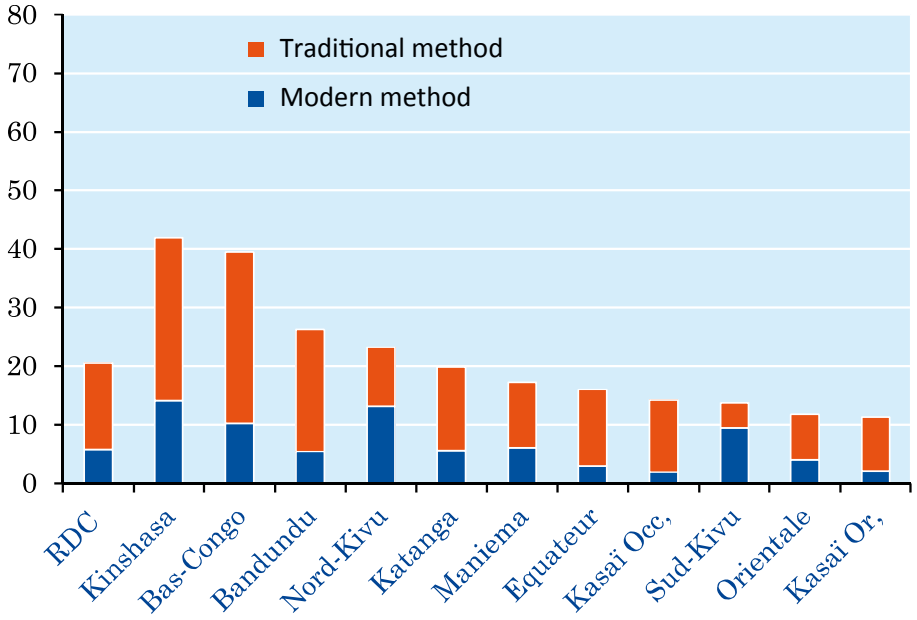
In the DRC, 12% of adolescents are married under the age 15 years, as are 39.1% of adolescents between 15 and 18 years of age. Married adolescents do not usually benefit from FP information or services to help to negotiate healthy sexual relations.

At the national level, 28% of adolescents between 15 and 19 have already started having children and 4% have given birth before they reach age 15. This situation is more common among adolescents living in rural areas (33.4%) than in urban areas (19.8%).

According to the 2010 MICS, 17.7% of women married or in union use a contraceptive method (5.4% use a modern contraceptive method, while 12.3% use a traditional method). The percentage of women using a modern contraceptive method varies considerably between

provinces (see Figure 3). Studies on contraceptive use indicate that more than 82% Congolese women married or living in union do not use any contraceptive method to prevent undesired pregnancies, either for spacing or limiting births.

Figure 3. Women in union using a contraceptive method by type of method and province (in %)



***Source** : DRC DHS, 2007*

According to the Demographic Health Survey (DHS) of 2007, seven in 10 men have never received any information regarding Family Planning. Indeed, men are often considered as an obstacle or a barrier to Family Planning. In many cases, men believe that authorizing women to use Family Planning will encourage prostitution.

The FP Program of the DRC still has considerable shortcomings, as shown through the indicators in the Table below.

Tableau 6. Evolution of key indicators on Family Planning

	Indicateur	1998 (ELS*)	2001 (MICS 2)	2007 (DHS)	2010 (MICS)
1	Percentage of women between 15 and 49 married or living in union and using a modern contraceptive method	4,6	4,0	5,8	5,4
2	Percentage of women in union between 15 and 49 using a contraceptive method (modern or traditional)	-	31,4	20,1	17,7
3	Percentage of women living in union, who do not wish to have a child/any more children, but are not using any contraceptive method	-	-	24	24
4	Mean number of children per woman (TFR)	7,2	7,1	6,3	-
5	Percentage of adolescents who have already given birth (live births)	-	20,1	19,0	22,5
6	Maternal mortality ratio	1837	1.289	549	-

3.7. Coordination of Family Planning activities

Coordination of Family Planning interventions and actors has been inadequate; interventions are often concentrated in the same areas, aiming at the same targets. In terms of implementation, access to FP services varies by province: some provinces have greater coverage of Family Planning activities (such as Sud-Kivu with 32 of 34 health zones served by FP) than others (such as the Province Occidentale, with 21 of 83 health zones covered, or Kasai Occidental with 10 out of 44 health zones covered) (see Table 3).

At the field level, there are FP programs that are not listed in the PNSR inventory and that do not provide data on their FP activities. Furthermore, prior to the creation of this document the DRC did not have any strategic plan that would establish the vision for Family Planning activities.

One glaring weakness in Family Planning programming that must be addressed is a lack of coordination. The PNSR provincial offices lack resources for supervision, and many are not aware of the organizations working in FP in their respective provinces. In short, it is necessary and urgent to address the problem of weak capacity and lack of resource mobilization if we are to achieve wider coverage of Family Planning services in health zones.

In summary :

- The government of the DRC will use this strategic plan to guide its efforts to strengthen Family Planning programming during the 2014-2020 period.
- The PNSR and PNSA will better coordinate and monitor the implementation of this strategic plan.

- FP implementing partners will align their FP programs with the objectives of this strategic plan in order to increase contraceptive prevalence.
- A detailed budget for this strategic plan will serve as a guide for planning and as an investment plan for donors.

3.8. Summary of key FP problems to be addressed, including service delivery

1. Service delivery

a. Low coverage and availability of clinical and community FP services, including youth-friendly services.

b. Financial barriers to FP services for clients.

c. Persistence of socio-cultural, legal and economic barriers that limit access to FP services, including youth-friendly services.

d. Low proportion of health facilities offering at least 3 contraceptive methods (6%).

e. Almost complete absence of Family Planning services in the private sector (for-profit organizations and enterprises).

2. Commodities

a. Lack of national estimates on the need for contraceptive products.

b. Inadequate stocks of contraceptives in comparison to the country's need.

c. Frequent stock outs in contraceptives at FP service delivery points.

d. Lack of a system to identify contraceptive needs at the national level.

e. Dependence on USAID- and UNFPA-funded projects to procure contraceptive supplies, which are then channeled primarily to their own intervention sites which only cover 124 of the 516 health zones in the country.

f. Lack of information on the management of contraceptive logistics and medical equipment.

3. Training/Workforce

a. Shortage of trained FP health providers (28%).

b. Less than 1,000 community health workers delivering contraceptive methods.

c. Little attention paid to FP in basic training curriculum for nurses and doctors.

4. information

a. Lack of information on contraceptive logistics.

b. Low capacity to manage FP data at all levels.

c. Multiple data collection tools, and low compliance/lack of timeliness in submission of information on service delivery and FP activities/programs.

5. Funding

a. Low level of funding for FP activities by the government and FP donors, with less than half of the country's health zones served.

b. Little involvement by the private sector in financing Family Planning.

6. Leadership/Governance (from a strategic, technical and governmental point of view).

a. Absence of coordination between FP stakeholders and interventions at all levels.

b. Lack of a common monitoring and evaluation framework.

c. Lack of a clear and shared vision of FP interventions.

7. Demand creation

a. Lack of community awareness and persistence of socio-cultural barriers.

b. Weak integration of comprehensive sexual education in primary and secondary school programs.

4 STRATEGIC PLAN FOR FAMILY PLANNING

4.1. Vision and guiding principles

According to DSRP II, the DRC's government policy on Family Planning is that all Congolese of reproductive age should have access to affordable, high-quality Family Planning services, regardless of their socio-economic background, geographical situation, and political or religious affiliations.

4.2. Goals and objectives of the National Strategic Plan for Family Planning

In the context of repositioning Family Planning, this strategic plan will contribute to improving the well-being of the Congolese population by 2020.

To this end, the plan includes the following objectives:

General objective

- Ensure a rapid and sustained increase in the use of effective modern contraceptive methods by Congolese women and men that wish to use them.

Objectifs Spécifiques

- Increase modern contraceptive prevalence estimated at 6.5% in 2013 (5.4% in 2010) to at least 19.0% by 2020 (corresponding to an increase of at least 1.5% per year).
- Ensure access to and use of modern contraceptive methods to at least 2.1 million additional women by 2020.

4.3. Sub-objectives of the National Strategic Plan for Family Planning

The following sub-objectives reflect the principles adopted by the international community to guide Family Planning programs. This strategic plan will then build on lessons learned from successful field experiences throughout Africa and beyond.

1. Obtain strong government support for Family Planning.
2. Increase access for men and women to Family Planning in the public and private sectors.
3. Increase the quality of Family Planning services.
4. Generate demand for Family Planning.
5. Develop and strengthen an efficient contraceptive logistics system
6. Implement a reliable evaluation system to measure results.

4.4. Implementation Plan

The implementation of this strategic plan will require :

1. The political will of the DRC government to ensure implementation of this strategic plan.
2. The capacity of existing programs to strengthen current efforts and to sustain progress already achieved.
3. The integration of community-based distribution of FP services to strengthen service delivery at health facilities, facilitated by the PNSR, which will monitor the implementation of all activities listed in the Table below.
4. The contributions (in both human and financial resources) of organizations already working and/or interested in working in Family Planning.
5. The important role of implementing partners (Ministry of Gender; Ministry of Planning; Ministry of Social Affairs; Ministry of Education, etc.).
6. The development and dissemination of documents on the norms and policies related to Family Planning;
7. The sustained will of existing partners to at least maintain their current levels of support to FP services.
8. The support of donors to meet the objectives of this plan.
9. The involvement of service delivery partners in both public and private sector health facilities to promote the benefits of Family Planning and ensure the quality of FP services.

Table 7 below presents two objectives and six sub-objectives of the plan that describe the main results to be achieved, the organizations responsible for each result, as well as the guidelines, targets and timeframes for launching these activities and achieving these different objectives.

Tableau 7. Conceptual framework for the implementation of the National FP Strategic Plan

Sous-objectif 1. **Obtain the effective and concrete commitment of the government to support Family Planning**			
Sub-objectives	**Outcomes**	**Guidelines**	**Timeframe**
1.1. Integrate family planning in the documents on socio-economic development and health policy of the DRC (PNDS, PPDS, DSCRP, Growth and Poverty Reduction Strategy Document, etc.), to be produced between 2014 and 2020	■ Ministry of Public Health (PNSR, D10 and DEP) ■ Ministry of Planning ■ Other associated ministries (Gender, Social Affairs, ESURS) ■ Ministry of the Environment (REDD+) ■ Ministry of Education	■ Review of existing documents ■ Elaborate new policy documents linked to poverty reduction, population and development, socio-economic issues, RH/FP, environmental protection	■ Starting in 2014
1.2. Create a budget line for contraceptive procurement (at both national and provincial levels)	■ DEP with the collaboration of PNSR and PNSA ■ CPP ■ The different targeted ministries	■ Health ■ Gender, Family Affairs and Children ■ Social Affairs ■ Rural development ■ Environmental Protection	■ Target: National level ■ 2013: $300,000 ■ 2014: $1,200,000 ■ 2015: $2,000,000 ■ From 2016 to 2020: $2,500,000
1.3. Integrate FP into the GIBS agenda (Interagency Group of Health Donors), including development, gender, youth & adolescents, and population issues	■ DEP with the collaboration of PNSR and PNSA ■ CPP ■ The different targeted ministries	■ Work with the different donor groups that deal with health financing, development, gender, youth and adolescent issues	■ 2014: Health Cluster ■ 2015: Donors
1.4. Create a law favorable to family planning, to protect minors and adolescents, and to promote gender	■ PNSR, PNSA, civil society, the UN, Parliament, FP stakeholders ■ Advocacy organizations ■ CTMP, CPP	■ Build on all efforts to create laws favorable to reproductive health and family planning	■ 2016: Adoption of a new law favorable to FP

Sous-objectif 2. **Increase access for men and women to family planning in the public and private sectors**			
Sub-objectives	**Outcomes**	**Guidelines**	**Timeframe**
2.1. Create partnerships between various FP stakeholders in each province	■ Ministries (PNSR, PNSA, DEP, GFC, AF, ESURS), NGOs and donors, professional associations (SCOGO, ANIC and UNAAC), FBOs.	■ Coalitions will work closely with other provinces	Number of provinces to cover: ■ 2014: 4 provinces ■ 2015: 7 provinces ■ 2016: 11 (all) provinces
2.2. Progressively increase the number of health zones with one referral health facility and at least 5 health centers offering FP services	■ MoH and NGOs ■ Donors	■ Integration of FP activities in all funded health programs ■ Collaboration with environmental protection programs ■ Work with organized community groups ■ Integration of CBD	Number of health zones to cover: ■ 2014: 250 HZ ■ 2015: 300 HZ ■ 2016: 400 HZ ■ 2017: 450 HZ ■ 2018-2020: 516 HZ
2.3. Progressively introduce community-based distribution (CBD) with at least 3 community health workers (CHWs) delivering FP services in each health area	■ PNSR, NGOs, Donors, Ministry of Gender, Social Affairs and other ministries, CBOs, FBOs.	■ CBD agents will offer non-clinical contraceptive methods, as well as providing supplies and reporting to health zones and NGOs.	Number of health zones to cover: ■ 2014: 250 HZ ■ 2015: 300 HZ ■ 2016: 400 HZ ■ 2017: 450 HZ ■ 2018-2020: 516 HZ
2.4. Extend integrated youth-friendly services to all health zones	■ PNSR, NGOs, Donors, Ministry of Gender ■ Ministry of Social Affairs and other ministries ■ CBOs ■ FBOs	■ Integrate youth-friendly services to all health zones with FP funding ■ Encourage the development of associations targeting young people and adolescents ■ Target existing youth movements and organizations (scouts, and others).	Target number of health zones served: ■ 2013: 60 ■ 2014: 100 ■ 2015: 200 ■ 2016: 300 HZ ■ 2017: 400 HZ ■ 2018-2020: 516 HZ
2.5. Extend FP services to the private sector	■ PNSR ■ Ministry of Labor and Social Welfare ■ FEC (Enterprises Federation of Congo) ■ Health at Work Program	■ Work with FEC to identify companies with operational health services ■ Target companies that previously offered FP services ■ Encourage companies to promote FP	■ From 2014

Sous-objectif 3. **Increase the quality of family planning services**			
Sub-objectives	**Outcomes**	**Guidelines**	**Timeframe**
3.1. Provide an increased range of at least 3 contraceptive methods in health facilities offering family planning	■ PNSR (Ministry of Public Health) ■ Donors ■ Service delivery organizations	■ The extended range of contraceptive methods should include at least: 1 long-acting method, 1 short-term method and 1 natural method ■ Review norms and protocols	Targets for the coming years (of facilities offering FP): ■ 2014: 50% ■ 2015: 60% ■ 2016: 80% ■ 2017-20: at least 80%
3.2. Provide FP training to health providers, including the development of training modules	■ PNSR and NGOs ■ PNSR, GFC, ESURS ■ PNSR and technical partners for the elaboration of training modules	■ Training of at least: ■ 2 health providers per health facility offering FP ■ 3 CBD agents per health area, or at least 85 per health zone ■ 1 trainer per implementing organization ■ At least 10 trainers per province	
3.3. Integrate family planning into training offered by medical and nursing schools, including issues on youth and adolescents	■ PNSR, NGOs ■ Health Sciences Division (6th Division) ■ Medical Schools ■ Nursing Schools	■ Adapt syllabus and update FP content ■ Include FP content in the internship curriculum for medical and nursing students	■ 2014: Situation analysis of FP training in medical and nursing schools ■ 2015: revision of training courses

Sous-objectif 4. **Generate demand for family planning**			
Sub-objectives	**Outcomes**	**Guidelines**	**Timeframe**
4.1. Create a detailed, tailored communication strategy to promote family planning	■ Ministries (Health, GFC, AF) ■ NGOs ■ Health at Work Program ■ Private telecommunication companies ■ Media	■ Identify existing communication tools ■ Identify actors in communication & media	Number of provinces to cover: ■ 2014: 4 provinces ■ 2015: 7 provinces ■ 2016: 11 (all) provinces
4.2. Develop and distribute educational, user-friendly materials (posters, leaflets, audiovisual materials) to clients, service providers and CBD agents, as well as young people and adolescents	■ Ministry of Public Health (PNSR, PNSA), Ministry of Gender, Family Affairs and Children, with their implementing partners ■ Youth and Sports ■ EPSP ■ ESURS		Number of health zones to cover: ■ 2014: 250 HZ ■ 2015: 300 HZ ■ 2016: 400 HZ ■ 2017: 450 HZ ■ 2018-2020: 516 HZ
4.3. Improve social norms regarding FP	■ PNSR ■ NGOs ■ Media	■ Work with the media, FBOs, civil society, local NGOs and FP implementing partners	Number of health zones to cover: ■ 2014: 250 HZ ■ 2015: 300 HZ ■ 2016: 400 HZ ■ 2017: 450 HZ ■ 2018-2020: 516 HZ

4.4. Develop programs targeting men, including young men	■ PNSR, NGOs, Donors, Ministry of Gender ■ Ministry of Social Affairs and other ministries ■ CBOs ■ FBOs	■ Develop partnerships with ministries: ESURS and EPSP; Youth and Sports; Labor and Social Welfare	Target number of health zones served: ■ 2013: 60 ■ 2014: 100 ■ 2015: 200 ■ 2016: 300 HZ ■ 2017: 400 HZ ■ 2018-2020: 516 HZ
4.5. Develop community mobilization strategies for FP	■ Ministries (Health, GFC, AF, ESURS, ENJ, etc.) , NGOs ■ Telecommunications companies (Orange, Airtel, Tigo, Vodacom)	■ Define roles and responsibilities of CBD agents ■ Define range of methods to offer and reporting system ■ Involve FBOs	■ From 2014

Sous-objectif 5. **Develop and strengthen an efficient contraceptive logistics system**			
Sub-objectives	**Organization(s) in charge**	**Guidelines**	**Timeframe and Target**
5.1. Create a multi-agency committee to ensure contraceptive security	■ PNSR, UNFPA, USAID, IMA-DFID, MERCK-MSD, PARSS, World Bank, FEDECAM, PNAM, MSH, others	■ Identify the organizations involved in purchasing contraceptives ■ Create a coalition of organizations involved in purchasing contraceptives	Number of provinces to cover: ■ 2014: 4 provinces ■ 2015: 7 provinces ■ 2016: 11 (all) provinces
5.2. Build capacity of the MoH/ PNSR and technical partners in all aspects of the contraceptive logistics process: forecasting, procurement, distribution, monitoring and accountability	■ PNSR, UNFPA, USAID, IMA-DFID, MERCK-MSD, PARSS, World Bank, FEDECAM, PNAM, MSH, others	■ Assist the PNSR to develop the capacity to procure and manage contraceptives, comply with international regulations, as well as operate the delivery system at the national, provincial and health zone levels	Number of health zones to cover: ■ 2014: 250 HZ ■ 2015: 300 HZ ■ 2016: 400 HZ ■ 2017: 450 HZ ■ 2018-2020: 516 HZ
5.3. Develop an information system to track the flow of contraceptives in the country (from the government, donors and partners on the field)	■ PNSR, UNFPA, USAID, IMA-DFID, MERCK-MSD, PARSS, World Bank, FEDECAM, PNAM, MSH, others	■ Work with the organizations involved in purchasing contraceptives ■ Work with the organizations involved in health system development and supply of medicines	Number of health zones to cover: ■ 2014: 250 HZ ■ 2015: 300 HZ ■ 2016: 400 HZ ■ 2017: 450 HZ ■ 2018-2020: 516 HZ
5.4. Ensure sufficient stocks of contraceptives in health facilities offering FP services	■ PNSR, UNFPA, USAID, IMA-DFID, MERCK-MSD, PARSS, World Bank, FEDECAM, PNAM, MSH, others.		Target number of health zones served: ■ 2013: 60 ■ 2014: 100 ■ 2015: 200 ■ 2016: 300 HZ ■ 2017: 400 HZ ■ 2018-2020: 516 HZ
5.5. Reduce the frequency of contraceptive stock outs in health facilities offering FP services	■ PNSR, UNFPA, USAID, IMA-DFID, MERCK-MSD, PARSS, World Bank, FEDECAM, PNAM, MSH, others	■ Develop functional system of supply at the level of health zones and health facilities	■ From 2014

Sous-objectif 6. **Implement a reliable system to monitor results**			
Sub-objectives	**Organization(s) in charge**	**Guidelines**	**Timeframe and Target**
6.1. Develop and update the list of health facilities offering FP services by health zone in all provinces	■ Ministry of Public Health ■ Technical and implementing partners ■ Donors	■ Establish a system to update the list of FP services, implementing partners and donors (list of actors and interventions in FP)	■ 2014: 1 province (Kinshasa) ■ 2015: 4 provinces ■ 2016: 11 (all) provinces
6.2. Enhance current capacity of the National Health Information System (SNIS) to transmit FP data	■ Ministry of Public Health (PNSR, 5th Division) ■ Donors ■ Implementing organizations ■ Advocacy and demand creation organizations	■ Use mobile phone technology to manage FP programs ■ Implement a reporting system (such as PMA2020)	■ 2014: 1 province (Kinshasa ■ 2015: 4 provinces ■ 2016: 11 (all) provinces
6.3. Produce annual reports that track progress on key indicators of the strategic plan	■ Ministry of Public Health with its technical, financial and implementing partners	■ Create a timetable for reports ■ Define minimum standards of each report	■ Target: electronic publication of full reports on FP indicators by province
6.4. Evaluate the National FP Strategic Plan	■ Ministry of Public Health with its technical partners and other ministries	■ Define key indicators for 2015 ■ Define key indicators for 2020	■ 2015: Mid-term evaluation and mid-course correction ■ 2020: Final evaluation of the strategic plan

4.5. Budgeting

The estimation of the costs associated with implementing Family Planning programs and increasing contraceptive prevalence is a difficult task, given that the public sector Family Planning services are often integrated into integrated health care packages. It is therefore difficult to isolate its specific costs, particularly when funding sources and service providers are numerous, as is the case of the DRC.

The calculations for this strategic plan were based on the GAP FP model developed by the Futures Institute to estimate funding needs associated with the increased use of Family Planning in a given country. These costs were grouped in four categories :

1 commoditiescosts 2 personnel costs; 3 overhead costs; and 4 support costs. The results obtained by year and category under the GAP model (see Table 8 and Figure 4 below) were as follows :

4.5.1. Cost of commodities

These costs were estimated based on the number of female users of each method, multiplied by the number of units necessary per user per year (or Couple-year of protection, CYP) and by the cost of each unit. The unitary cost used for each method is its price on the market in Kinshasa, as provided in the 2012 database of the Reproductive Health Supplies Coalition. The objective of this Strategic Plan is to ensure access to and uptake of modern contraceptive methods to at least 2.1 million additional women by 2020, which will require a three-fold increase in the number of female users between 2013 and 2020 as well as a greater increase in the use of long-acting contraceptives (implants and injectables, see Figure 5 below). The corresponding amount of funding needed comes to $54 million (US dollars) for the entire 2014-2020 period.

4.5.2. Personnel costs

Except for condoms, nurses are the main counselors and providers of contraceptive methods; they usually work in public health facilities that are often managed by private partners or supported by private funding. One could assume that the increased workload associated with the expected tripling of female contraceptive users by 2020 could be completely absorbed by the current workforce in these health centers. However, it seemed more realistic to estimate some additional costs. We used the values of "personnel costs for the distribution of products" estimated for each method, based on the various experiences offered in the GAP model. The additional personnel costs amounted to $47 million (US Dollars) for the entire 2014-2020 period.

4.5.3. Overhead costs

Overhead costs include utilities such as electricity and water, as well as rent and maintenance, administrative costs, and security for health facilities. According to some analysts, the additional costs resulting from the expansion of Family Planning services in these facilities can be absorbed by current budgets, as they mainly include fixed costs that need to be covered in any event. However, this hypothesis is not necessarily realistic and does not consider the need to renovate some health centers. Therefore, we estimated the additional overhead costs using a variable rate based on the contraceptive methods and personnel costs previously calculated

under the GAP model. The additional overhead costs associated to the extension of Family Planning activities amount to $51.5 million (US dollars) for the entire 2014-2020 period.

4.5.4. Support costs

Under the GAP model, support costs are divided into seven types of activities that support the strategic plan's objectives and improve the efficiency of its actions. The funding needed for FP programs was estimated at $13 million (US dollars) per year, or $90 million (US dollars) for the entire 2014-2020 period. This funding corresponds to the seven types of activities as follows :

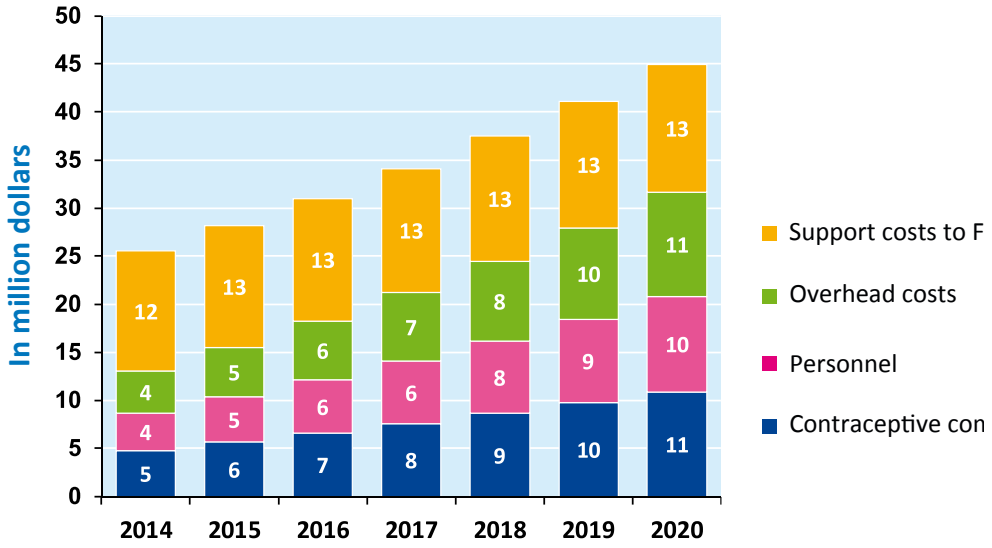
1. **Creation of a receptive political and institutional environment** : annual cost estimated at $400,000 (U.S.), corresponding to the organization of four high-level meetings per year (involving Ministers, MPs, Provincial Medical Inspectors, etc.) and the printing of various documents (posters, leaflets, etc.)
2. **Training of health providers** : annual cost estimated at $4 million (U.S.) , corresponding to the training of health providers and community health workers every two years in approximately 500 health zones (the average cost of one training session is estimated at $16,000 U.S.)
3. **Capacity building for management** : annual cost estimated at $1 million (U.S.) , corresponding to the training of administrative staff every two years in approximately 500 health zones (the average cost of one training session is estimated at $10,000 U.S..)
4. **Communication activities in all provinces, including Family Planning campaigns** : annual cost estimated at $3.6 million (U.S.) , corresponding to at least one awareness campaign per month per year in all 11 provinces, representing $300,000 (U.S.) per province and an additional $300,000 for activities implemented at the national level.
5. **Research, publications and dissemination of findings and evaluation reports** : a flat rate of $1 million per year was provisionally budgeted for these activities, which include the dissemination of findings, seminars to communicate research results, the printing of research reports, and media-oriented actions
6. **Logistics, including the implementation of a logistical management system** : a flat rate of $2 million (U.S.) per year was provisionally budgeted for these activities, including the implementation of an efficient and sustainable logistical management system, which will take time and will probably need external expertise.
7. **Monitoring & Evaluation** : a flat rate of $1 million (U.S.) per year was provisionally budgeted for these activities, including the implementation of an efficient monitoring and evaluation system enabling the rapid production of detailed annual reports on key indicators of results obtained from the strategic plan

Overall, the funding needed to operationalize this strategic plan is estimated at $242 million US dollars for the entire 2014-2020 period. If one excludes personnel costs and additional overhead costs and assumes instead that they are entirely absorbed by the facilities' current budgets, the necessary funding amounts to $144 million US dollars. As in every prospective cost estimate, these amounts merit periodic review and more detailed estimations.

Tableau 8. Costs by component (in million USD, 2012 value) of the National FP Strategic Plan 2014-2020, under the selected hypotheses

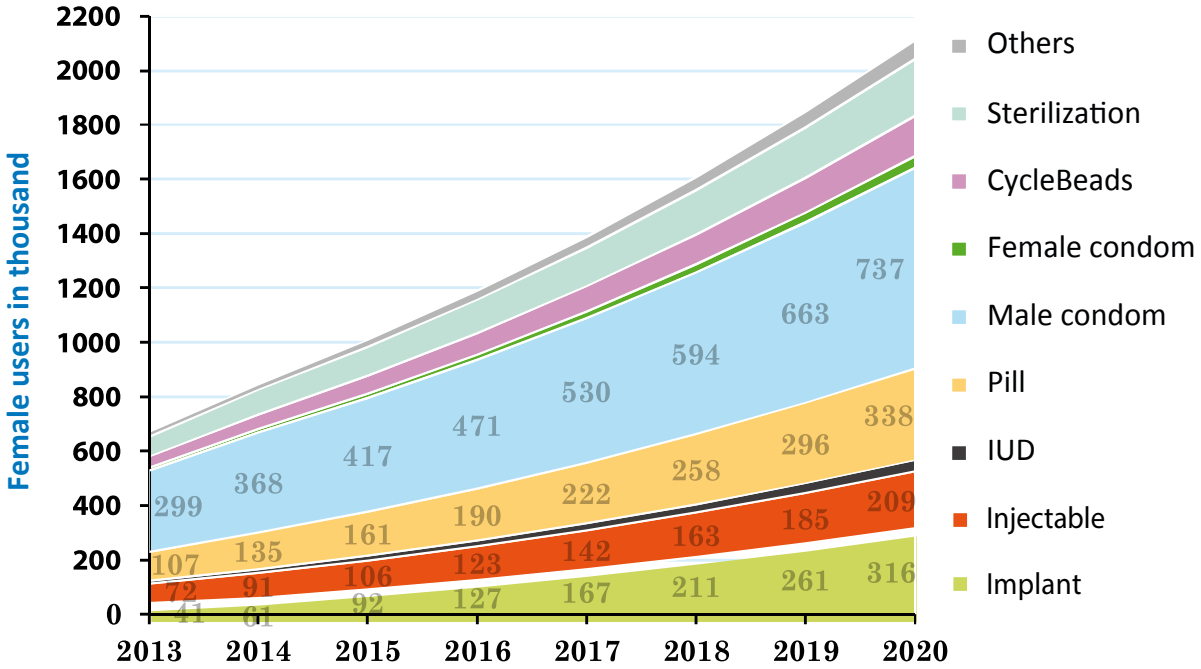
Costs to achieve rapid uptake of modern contraception					
Years	Contraceptive commodities	Personnel	Overhead costs	Support Costs	Total
2014	$ 4,762	$ 3,907	$ 4,373	$ 12,493	$ 25,535
2015	$ 5,652	$ 4,684	$ 5,209	$ 12,618	$ 28163
2016	$ 6,599	$ 5,542	$ 6,136	$ 12,744	$ 31,020
2017	$ 7,600	$ 6,488	$ 7,158	$ 12,871	$ 34,117
2018	$ 8,654	$ 7,527	$ 8,281	$ 13,000	$ 37,461
2019	$ 9,758	$ 8,663	$ 9,511	$ 13,130	$ 41,062
2020	$ 10,908	$ 9,904	$ 10,855	$ 13,261	$ 44,928
Total 2014-2020	$ 53,933	$ 46,715	$ 51,522	$ 90,117	$ 242,287
% by category	22,3%	19,3%	21,3%	37,2%	100,0%
Commodities & Support costs	$ 53,933			$ 90,117	$ 144,050
% by category	37,4%			62,6%	100,0%

Figure 4. Projection of costs by component estimated from 2014 to 2020 (in million USD, 2012 value), under the rapid uptake of modern contraception hypothesis (+1.5 point per year)



The hypothesized evolution in the contraceptive method mix leads to the increases in the number of female users by method, shown in Figure 5 below.

Figure 5. Evolution of the number of modern contraceptive users by method projected from 2014 to 2020 (in thousand users), under the hypothesis of rapid uptake of modern contraception (+1.5 point per year)



4.5.5. Current and future funding

In 2013, the cost of purchasing the contraceptive commodities listed above was expected at $10.6 million dollars, or a little more than twice as much as the current estimated annual need. The main contributors are the same as in previous years: USAID and UNFPA. DFID will also contribute to the purchase of contraceptives as well as the Ministry of Public Health, which has allocated $760,000 for contraceptive procurement. Additionally, the PARSS Project (Health Sector Strengthening Project, financed by the World Bank) will devote a substantial amount to the procurement of contraceptive commodities.

The information compiled for this analysis shows that the current levels of external funding for the purchase of contraceptives can be maintained at a similar level to the current one. Moreover, the Ministry of Public Health's contribution could reach $2 million dollars in 2014, and over $2 million after 2014.

4.6. Monitoring & Evaluation of the FP Strategic Plan

The Government of the DRC, through the Ministry of Public Health programs including the PNSR and others, and other ministries involved in the implementation of this Strategic Plan will be responsible for monitoring and evaluating the implementation of this plan with technical assistance from stakeholders working in the field.

If the 2013 DHS shows a significant increase in the national contraceptive prevalence rate, the objective of this plan could be reevaluated to set a new contraceptive prevalence target at the national level to be reached by 2020.

The monitoring of this plan will be based on four data sources:

- Routine service statistics generated by the SNIS;
- Periodic surveys to the population at the national level (DHS, MICS, PMA2020);
- Special studies with specific objectives;
- Administrative documents from the government, the PNSR or others.

Table 9 below shows some selected indicators by objective and sub-objective (from Table 7).

Tableau 9. Selected indicators to monitor the objectives and sub-objectives of the strategic plan

Objectives or sub-objectives	Indicator	Data source
Increase modern contraceptive prevalence from 6.5% to at least 19.0% by 2020 (at least 1.5% per year)	■ Percentage of women married or living in union aged 15-49 using a modern contraceptive method ■ Percentage of sexually active young women and adolescents using a modern contraceptive method	EDS, MICS PMA 2020
Provide modern contraceptive methods to at least 2.1 additional women by 2020	■ Couple-year of protection (a "proxy" indicator for the number of women provided with modern methods)	SNIS
For each sub-objective, two illustrative examples of indicators are presented here.		
1. Obtain strong commitment from the government in support of Family Planning 1.2. Create a budget line for the purchase of contraceptive products 1.4. Create a law favorable to Family Planning	Amount of the government's budget line to purchase contraceptive products, per year Adoption of a law favoring FP	Official governmental documents
2. Increase access to Family Planning services 2.1. Create a FP Coalition in each province 2.2. Progressively increase the number of health zones and health areas offering FP	■ Number of provinces with at least one operational FP Coalition (that meets on a regular basis) ■ Number of health zones offering FP services. ■ Number of health areas offering FP services	■ Administrative files from the PNSR ■ Mapping studies
3. Improve the quality of FP services 3.1. Provide an extended range of at least 3 modern FP methods 3.2. Train health providers in Family Planning	■ Percentage of health facilities that offer at least 3 contraceptive methods ■ Percentage of health facilities offering FP with at least 1 person trained in FP	■ Service Delivery Point Survey (UNICEF PTME, PMA2020, others.) ■ Service Delivery Point Surveys (UNICEF PMTCT, PMA2020, others.)

4. Generate demand for Family Planning 4.1. Develop and disseminate FP educational materials 4.2. Improve community norms and perceptions of FP	■ Percentage of the population who have seen or heard FP messages ■ Percentage of the population favorable to FP	■ DHS, PMA2020 ■ DHS, PMA2020
5. Develop and strengthen an efficient contraceptive logistics management system 5.1. Develop an information system that effectively monitors the flow of contraceptives entering the country or purchased locally by the government, donors and partners. 5.2. Reduce the frequency of stock outs at health facilities offering FP services	■ Presence of an information system monitoring the flow of contraceptives at all levels ■ Percentage of health facilities offering FP services that have not had any contraceptive stock out in the past 6 months	■ Documents/files from the MoH and PNSR ■ Service Delivery Point Surveys
6. Implement a reliable system to evaluate results 6.1 Develop and update the list of health facilities (created by UNICEF in 2012) offering FP services by health zone in all provinces 6.2 Enhance current capacity of the National Health Information System in FP data transmission	■ Existence of an updated list of health facilities offering FP services by health zone in all provinces ■ Number and percentage of health facilities sending their statistics on FP activities (according to the SNIS)	■ Dossiers administratifs au niveau du PNSR ■ SNIS (new system)

ANNEX : RESULTS OF THE PLANNING WORKSHOP

A PLANNING WORKSHOP was held from May 27 - June 2, 2013, with Provincial Ministers, Provincial Medical Inspectors, la DEP, national and international NGOs, and donors at the Hotel Sultani in Kinshasa Gombe. This annex contains key points from this workshop, which became the basis for the final draft of the Strategic Plan.

Implementation Strategy of the FP Strategic Plan

1. Service delivery

a. Develop activities and community-based distribution services in all health areas.

b. Develop clinical activities and services in all health areas.

c. Develop youth and adolescent-friendly Service Delivery Points (SDP).

d. Integrate Family Planning services in the Maternal and Neonatal Care Package.

2. FP commodities

a. Integrate the purchase of contraceptives into the agendas of government and donors.

b. Integrate the contraceptive security strategy

3. Training

a. Integrate Family Planning in the curriculum of secondary schools, higher education and universities.

b. Develop continuing education training modules adapted to environments with limited resources (short-term, low-cost and practical).

c. Develop on-the-job FP training courses

d. Train teachers in comprehensive sexual education for youth and adolescents

4. Information

a. Develop all aspects of the system needed to improve the collection of FP data.

5. Funding

a. Mobilize funds from both the public and private sectors at all levels to finance FP activities, including the purchase of contraceptives.

b. Attract new FP donors

6. Leadership et coordination

a. Revitalize/extend multisectoral committees for FP at all levels (Ministries of Gender, Education, Social Affairs, Budget, the Environment, etc.)

b. Develop internal and external partnerships with different actors in Family Planning through the creation of national and provincial coalitions to improve coordination.

7. Demand creation

a. Promote FP through the private and public sectors, as well as at the community level (including religious groups).

LIST OF CONTRIBUTORS

- ABEF
- ADVANCE FAMILY PLANNING (AFP)
- ASD
- CARE INTERNATIONAL
- C-CHANGE/FHI360
- CONDUITE DE LA FECONDITE
- DEP (SANTE ; PLAN ; GENRE FEMME ET ENFANTS, …)
- FUTURES GROUP
- IRC
- IRD
- LES COORDINATIONATIONS PROVINCIALES DE PNSR
- LES MINISTERES PROVINCIAUX DE SANTE ; GENRE FAMILLE ET ENFANTS ; MINISTERE DU PLAN ;
- MAMAN ANSAR
- MERLIN
- MINISTERE DU PLAN
- MINISTRE DE GENRE FEMME ET ENFANT
- MSH
- OMS
- PATHFINDER INTERNATIONAL
- PNSA
- PNSR
- PROJET PARSS/BANQUE MONDIALE
- PSI/ASF
- SAVE THE CHILDREN
- SCOGO
- SECRETARIAT GENERAL A LA SANTE
- TULANE UNIVERSITY
- UCPPF
- UNFPA
- USAID

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