PROGRAM DESCRIPTION

Activity 5

USAID Human Resources for Health (HRH), Quality Management and Community Health Systems

Table of Contents

List of Acronyms 3
Definitions of terms 4
Background and context 5
Geographical Focus 6
Sub purpose 1: Strengthen Human Resources for Health management systems 6
Output 1.1: Strengthened health workforce performance management 7
Output 1.2: Enhanced workplace environment 8
Output 1.3: Strengthened HRH management deployment and retention functions 8
Sub Purpose 2: Improved Quality management systems 9
Output 2.1: Strengthened Quality Planning 11
Output 2.3: Strengthening Quality Improvement 12
Sub purpose 3: Strengthen Community Health Systems at National and County levels 12
Output 3.1: Strengthened health systems for improved quality of community health services 13
Output 3.2: Strengthened community health systems for enhance equitable distribution of services 13
Relationship with other Health Investments 14
Partnerships 15

I. List of Acronyms

BMGF	Bill and Melinda Gates Foundation
CDCS	Country Development Cooperation Strategy
CHS	Community Health Strategy
DFH	Division of Family Health
FH	Family Planning
FY	Financial Year
GOK	Government of Kenya
HCW	Health Care Workers
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HPN	Health Population and Nutrition
HRIS	Human Resources Information Systems
HRH	Human Resources for Health
HSS	Health Systems Strengthening
ICH	Integrated Community Health
J2SR	Journey to Self Reliance
JHIC	Joint Health Improvement Committee
KHQIF	Kenya Health Quality Improvement Framework
KEPHS	Kenya Essential Package for Health Services
KHQIF	Kenya Health Quality Improvement Framework
KQM	Kenya Quality Model
KQM	Kenya Quality Model for Health
MNHQC	Maternal and Neonatal Health Quality of Care
MoH	Ministry of Health
PEPFAR	President's Emergency Plan for AIDs Relief
PHC	Primary Health Care
PMI	Presidential Malaria Initiative
QA	Quality Assurance
QI	Quality Improvement
RMNCAH	Reproductive Maternal Neonatal Child and Adolescents Health
TB	Tuberculosis
USG	United States Government
UHC	Universal Health Coverage
UNICEF	United Nations International Children's Emergency Fund
USAID	United States Assistance for International Development
WHO	World Health Organization

II. Definitions of terms

Health workers: has been defined as all people engaged in the promotion, protection, or improvement of the health of the population. They could be skilled or unskilled, formal or informal, professional or nonprofessional.

Health workforce: WHO has also defined health workforce as all people engaged in actions whose primary intent is to enhance health"

Health systems: The World Health Organization defines health systems as follows: A health system consists of all organizations, people and actions whose primary intent is to promote, restore or maintain health. This includes efforts to influence determinants of health as well as more direct health-improving activities.

Human resources for health Systems: this is one of the WHO health systems pillars that focus on the health workforce. The main focus is ensuring a healthy workforce that is available, competent, responsive and productive. This is achieved through strengthening training, financing, performance, and retention.

Community health services: These refer to health services provided at level
(Community level) one of service delivery as defined in the Kenya Essential Package of Health**.**

Community health systems: These are all systems that support efficiency and effectiveness in delivery of community health services.

Community Health Workers: This refers to the subset of health workers who primarily provide health services at level one (community Level). In Kenya this workforce can be categorized further as Community Health assistants - which is a formal cadre as defined in the scheme of service, and Community Health Volunteers- which is an informal cadre that supports community health services.

Quality Assurance: This is a process of assessing or monitoring compliance against evidence-based standards or regulations (e.g., audits, accreditation, checklists, etc.)

Quality Improvement: The Model for Improvement[1] emphasizes changes in health care processes and systems to enable evidence-based interventions to achieve desired health outcomes. Quality improvement is the act of introducing changes to the health care process to yield safe, effective, and efficient delivery of health care.

Quality Management: All activities of the overall management function that determine the quality policy, objectives, and responsibilities, and implement them by means such as quality planning, quality control, and quality improvement within the quality system[2]

---

[1] Langley GL, Moen R, Nolan KM, Nolan TW, Norman CL, Provost LP. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance* (2nd edition). San Francisco: Jossey-Bass Publishers; 2009

[2] . Juran JM, Godfrey AB. Juran's quality handbook, fifth edition. McGraw-Hill; 1999.

III. Background and context

As part of informing the new Country Development Cooperation Strategy (CDCS)(FY 21-25), USAID/KEA is embarking on a deliberate journey to support Kenya towards the journey to self-reliance (J2SR). A critical part of this process is developing diverse, meaningful and strong health systems to be responsive to existing health challenges and resilient to emerging health issues such as COVID-19. USAID/KEA through the Health Population and Nutrition (HPN) Office has embarked on designing a robust Health Systems Strengthening (HSS) program that build up on existing investments in HSS and service delivery for enhanced efficiency in responding to needs of both patients and the broader health sector in Kenya.

USAID's engagement and support is intended to align with the Government of Kenya's constitution 2010, and health act 2017, as well as health programs such as PEPFAR, PMI, RMNCAH, and other USG investment in Kenya to enhance synergies and efficiencies for support.

The activity is expected to ensure there are stronger, functional national and county health systems with adequate capacity to ensure equity, quality and resource optimization in health services delivery at all levels of the health system. The recipient should implement innovative approaches to build on the work already done in strengthening human resources for health (HRH), quality management and community health systems, working collaboratively with GoK (national and county), private sector, communities, and development partners in the areas of interest. The recipient should use various approaches to measure progress in building maturity and sustainability of the supported systems along the journey to self-reliance.

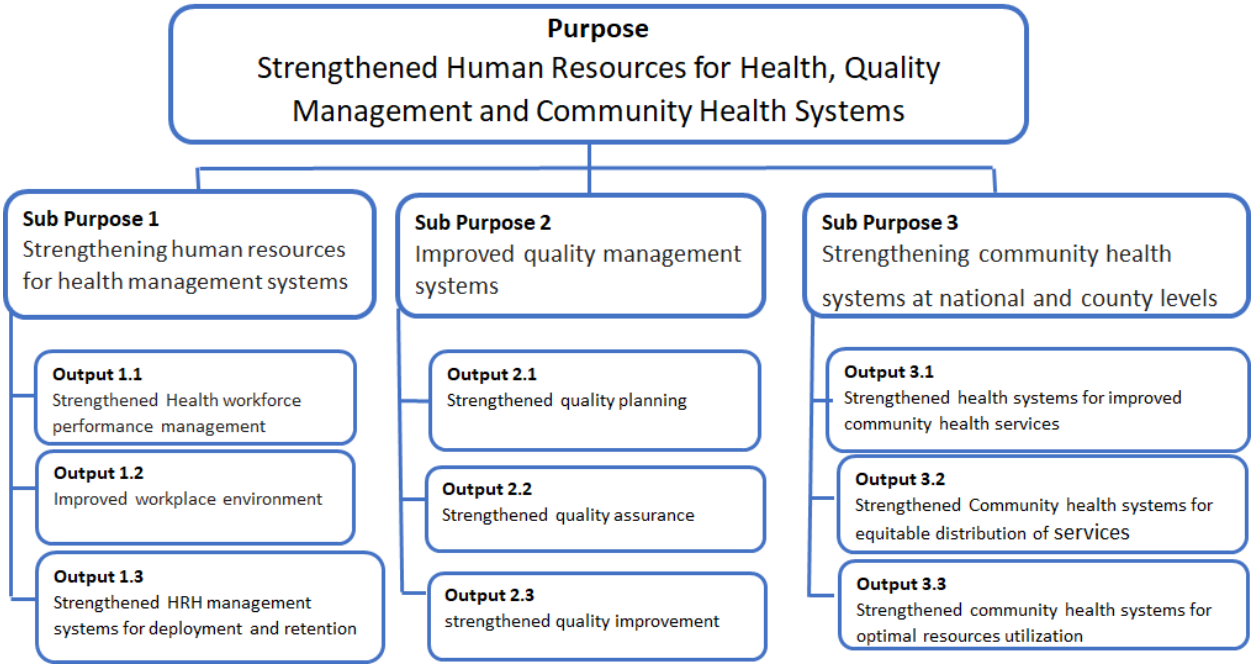
Co-creation between the recipient(s) and other players including government departments and agencies, as well as existing and new health systems stakeholders is highly recommended to ensure minimal duplication or overlap while enhancing synergies for efficiency in achieving the expected outcomes.

Results framework

USAID's HSS support is based on intensive analysis of the current situation, stakeholders' engagements, and review of relevant documents and reports. As a result, this HSS activity is designed with a purpose to *"Strengthen human resources for health, quality management, and community health systems at national and county levels to Improve Equity, Resource Optimization, and Quality of Essential Health Services.*

Activity 5 has three sub-purposes: 1) strengthening human resources for health (HRH) management systems, 2) enhanced quality management systems, and 3) strengthening community health systems at national and county levels. The focus of this activity should be to build on existing interventions, identify existing gaps, and enhance maturity of the supported systems towards sustainability and in the journey to self-reliance.

Figure 1: Strengthened Human Resources for Health, Quality Management and Community Health Systems Activity's Results Framework



Geographical Focus

Activity	Geographic Coverage	Total Estimated Amount (USD)
Health Systems for Quality Health Systems		
Activity 5 - USAID Human Resources for Health (HRH), Quality Management and Community Health Systems	National and COG level and 20 counties – these have budget level >30% (F1 & F2 on county zoning table) Zone 1 [13 of 13 counties] Zone 3[5 of 8 counties] Zone 4 [2 of 5 counties]	$15,000,000

IV. Sub purpose 1: Strengthen Human Resources for Health management systems

Introduction

Kenya is one of the countries with a very low ratio of health workers to population, estimated at 15/10,000 against WHO recommended standards of 23/10,000 as stated in the Kenya HRH strategy III. Similarly, a report by USAID on Workload Indicators for Staffing Norms (WISN) 2019, indicates that at the facility- level in various counties, the workload for the various cadres of health workers is much higher than set or desired norms per cadre. Implementation of the Kenya Constitution 2010, saw devolution of the health sector to the 47 counties, including the HRH and community health functions. Counties have continued to struggle with the management of HRH functions, in part due to weakness in the HRH management systems. The distribution of workforce across and within counties varies significantly, with some of the counties having extremely low

numbers of health workers to effectively provide quality services. The national Health accounts 2018/19 indicates that close to 70% of the wage bill is dedicated to personnel emoluments, while at the same time the counties are operating at below capacity in terms of numbers and skills mix needed to provide equitable, acceptable, quality health services. USG investments in the health sector in Kenya would suffer greatly if there is inefficient use of resources due to insufficient HCW numbers and skills mix at the facility and community level. As a result, the USG has continued to invest in strengthening HRH systems at the national and county level as well as contracting health workers to bridge the existing gap of workforce for services such as HIV/AIDs, RMNCAH and malaria. Despite efforts and achievements this far, more needs to be done to ensure sustained results of HRH systems' investments, maturity of weak components, and to support the journey to self-reliance.

For this sub purpose, the recipient is intended to focus on building the capacity of national and sub-national (county) human resources for health (HRH) management systems to address issues pertaining to health worker productivity, retention, and quality of services delivered. Weak systems have resulted in inequitable distribution of health workforce, weak optimization of the available health workforce, health worker morale and motivation issues, and overall quality of services delivered.

The recipient is expected to implement proposed approaches that should strengthen the existing HRH management systems to address the identified barriers.

It is expected that the proposed interventions should lead to the three key outputs as described below.

HRH Systems Barrier: Weak human resources for health systems at the national and county levels for effective and quality service delivery (especially HIV/AIDS, RMNCAH and Malaria).

To address the identified barrier, USAID expects the recipient to implement the proposed strategies that should result in the following outputs:

Output 1.1: Strengthened health workforce performance management

The recipient is expected to implement proposed approaches to ensure stronger systems to support health workforce productivity.

Illustrative outcomes shall include but are not limited to:

- Enhanced preservice and in-service training programs to ensure the workforce is well prepared and responsive to the needs of the populations they serve, especially for the HIV/AIDS, RMNCAH,and Malaria interventions.
- Health workforce hiring and deployment systems -- those that are responsible for hiring, deploying, and reallocating workers --lead to appropriate distribution of workers that provide more equitable services to populations.
- Improved functioning of health workforce performance management and supervision systems to enable continuous monitoring and resulting in improved productivity and performance, including reduced absenteeism across facilities.
- Improved entry, quality and use of data (HRIS and other service delivery) to monitor HRH performance

- Strengthened government departments (at national and county levels) and regulatory bodies to enhance and enforce health workforce norms and standards of practice.
- Strengthened county government HRH management systems to enhance efficiency and reduce redundancies of processes for health worker planning, hiring, deployment, and remuneration.
- Further strengthened and scaled HRIS systems for completeness, accuracy, and capacity for utilization of the data for local decision making.

Output 1.2: Enhanced workplace environment

The recipient should implement proposed approaches that are expected to strengthen systems for improving the workplace environment for facility and community-based health workers. A supportive work environment is essential for delivery of quality health services, to minimize disruption of services, minimal labor disputes and ensure a motivated workforce. Illustrative outcomes shall include but are not limited to:

- Strengthened regulatory functions to set and enforce workplace environment standards and norms.
- Strengthened county government functions that enforce workplace environment at all levels of service delivery
- Enhanced workplace councils and engagements between employers and employees' representatives to ensure regular, meaningful worker-employer engagements (at all levels) contributing to an improved workplace environment (hence minimize labor disputes and strikes)
- Innovative approaches to mitigate health workforce labor disputes

Output 1.3: Strengthened HRH management deployment and retention functions

The recipient should implement approaches to strengthen workforce retention systems to create a supportive environment to increase and sustain delivery of high quality services, especially in high disease burden regions. The retention systems should cover both governments' hired workforce, donor supported/contracted workforce (before and after transition) as well as non-government facility workforce especially those who render critical HIV/AIDS, RMNCAH, and malaria-related services. Illustrative outcomes should include but are not limited to the following:

- Health workforce hiring and deployment systems are demonstrating deployment and reallocation of workers that leads to distribution of workers that provide more equitable services to populations.
- Strengthen county government HRH management systems to enhance efficiency and reduce redundancies of processes for health worker hiring, deployment, and remuneration.
- Further strengthen and scale the HRIS systems for completeness, accuracy and capacity on data use at all levels of decision making namely national, county and facility.
- Established county governments retention strategies in place and devise approaches to strengthen the strategies, based on county specific needs.
- Established donor supported workforce transition plans, in coordination with national and county governments, that enable sustained HRH required to maintain service delivery.
- Established county and cadre specific dependency HCW ratios (numbers of workers hired by GoK against number of workers hired by USG). Work together with the government

(national and county) as well as other stakeholders, on approaches to improve the ratios while retaining HCWs and not compromising on quality of care.

- Enhanced relationships and coordination with the Ministry of Health and Ministry of Public Service, to analyze health workforce market dynamics and advise on donor supported workforce, for enhanced retention post donor exits/ transition.

V. Sub Purpose 2: Improved Quality management systems

Introduction

Quality of care is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.[3] USAID defines quality health services as those that respond to patient and population needs to consistently provide safe, effective, and reliable healthcare and medical products for all people through data-driven, continuous process improvement and evidence-based research. Quality improvement refers to the iterative cycle of rapidly testing changes to care processes to bridge the gap between **what is** happening and **what should be** happening. However, program implementation is limited by available resources (human, commodities, and infrastructure), necessitating prioritization and resource optimization. Systematically improving health system performance and quality of healthcare can be supported by a well-defined quality policy and a sound implementation strategy. Success also depends on establishing an environment that is conducive for continuous process improvement through effective collaboration between health providers, health managers, and beneficiaries of health services.

Ensuring quality health services goes beyond increasing inputs such as knowledge and resources, but also requires improving processes throughout the health system to enable and support provision of high-quality health care, which populations and individuals rightly expect. Taking a systems perspective, including understanding all aspects of the system (e.g. supplies, information, governance, etc.) that influence quality service provision and orienting systems to the delivery and improvement of quality, are fundamental to progress and to meeting the expectations of both populations and health-care workers. UHC emphasizes access to quality essential health care services for all. In this activity, there is a specific focus on improving the quality of HIV/AIDS, RMNCAH and Malaria interventions.

In every country, there are opportunities to improve the quality and performance of the health system, and to engage all stakeholders (including civil society) in the improvement processes. In Kenya, efforts to enhance quality of health service have taken various historical milestones as reflected in Figure 2 below. The journey reflects the development, ownership and institutionalization of Kenya Quality Model for Health (KQMH). The journey as detailed in the KQMH document has seen critical success and failures in both quality assurance (QA) and quality improvement (QI) initiatives that the recipient should learn from and build on as part of the proposed strategies. Notable QA successes have occurred in some counties including: i.) Functional quality management structures; ii.) Full-fledged county-level officers charged with

[3] Institute of Medicine. 1990. Medicare: a strategy for quality assurance, volume I. Washington (DC): National Academies Press.

overseeing the quality-of-care elements; iii.) Recognizable national framework for quality management; iv.) Adequate capacities at county level to conduct quality of care assessments and training; and v.) Roll-out of an electronic KQMH quality assessment tool that is aligned to the DHIS platform. Additionally, QI successes include advancement of quality-of-care improvements by different health departments and programs e.g., HIV, Malaria, MNCH, FH. Overall, some of the challenges affecting quality of care include but are not limited to: i.) Lack of effective coordination (both national and county levels) in quality improvement models, leaving health facilities at the mercy of non-state actors; ii.) Strained intergovernmental relations affecting funds release; iii.) low HRH capacity and morale affecting implementation of quality services; iv.) Donor environment favoring Short-term, vertical funding of healthcare improvement initiatives.

Figure 2: The Quality of Care: Journey to Institutionalization in Kenya

A health system should ensure the quality of health services across the six areas or dimensions of quality health services, as stated below:

- **Effective,** such that care is adherent to an evidence base and results in improved health outcomes for individuals and communities, based on need;
- **Efficient** and delivered in a manner that optimizes available resources and avoids waste;
- **Accessible;** provided in a timely, geographically suitable, and appropriate setting, where skills and resources are aligned with patient and community need;
- **Acceptable and patient-centered,** taking into account the preferences and aspirations of individual service users and the cultures of their communities;
- **Equitable** and delivered uniformly, such that it does not vary in quality because of personal characteristics such as gender, race, ethnicity, geographical location, or socioeconomic status; and
- **Safe**, minimizing risks and harm to service users and/or the community at large.

Barrier: Poor Quality Management Systems

A recent assessment by USAID KEA and review of relevant documents indicates poor quality management systems in the country as a result of weak health systems. There is a need to direct attention toward improving patient experience of care especially in the public facilities. Poor quality of health services spans human resources, medical products and technology, infrastructure and leadership standards. These weaknesses often go unnoticed, in part because consumers have no idea what the expected standard should be or how to actively engage the government to advocate for improved quality of care. There is a need therefore, to strengthen norms and standards of practice, products, and infrastructure, enhance the process of enforcing compliance to these standards of practice, ensure continuous quality improvement by monitoring compliance and improvement teams taking corrective actions when appropriate.

The recipient is expected to implement proposed approaches to ensure stronger systems to support quality management systems through but not limited to the suggested outputs;

Sub-purpose 2, *Improved quality management systems* is intended to be achieved through the three outputs listed below. The recipient should suggest best intervention strategies for each output.

Output 2.1: Strengthened Quality Planning

The recipient is expected to implement the proposed strategies to ensure there are clear and functional quality planning systems at the national and county levels.

Illustrative outcomes should include but are not limited to the following:

- Established data-informed systems for analyzing quality management gaps
- Established systems for quality management resources mapping and mobilization (including infrastructure, health workforce and capacity development)
- Establishing systems for quality management plans and their executions

Output 2.2: Strengthened Quality Assurance

Quality assurance systems focus on enhancing the quality of patient care towards acceptable levels within available resources. The recipient should suggest strategies to ensure there are stronger quality assurance systems at national and county levels.

Illustrative outcomes include but are not limited to the following;

- Strengthen quality assurance structures and processes at the national and county levels
- Establish process of quality assurance capacity development and corrective measures
- engagement of regulators at various levels to ensure quality of care is within required standards
- Strengthened oversight on implementation of standards and norms of practice

Output 2.3: Strengthening Quality Improvement

The recipient is expected to implement strategies that strengthen quality improvement systems at the national and county levels.

Illustrative outcomes should include but not limited to:

- Strengthened mechanisms for reviewing and setting quality standards and norms for enhanced quality of care at all levels of service delivery
- Strengthened continuous quality improvement teams and improvement coaching structures at county and national levels
- Strengthened learning and adapting processes based on data from improvement teams, reports from quality improvement activities
- Strengthened referral systems for enhanced access to quality care by patients

VI. Sub purpose 3: Strengthen Community Health Systems at National and County levels

Introduction

Kenya has made some remarkable strides to mainstream community health services within its health system as a critical part of community based primary healthcare (PHC) in line with the goals of the Alma Ata declaration of 1978. However, existing barriers of weak community health systems such as the limited fiscal space for community health, sub-optimal mechanisms to guarantee quality of community health services and poor linkages between community and higher levels of healthcare delivery system has been a hindrance in the realization of community health's full potential. This has contributed to poor quality of care, inequities of access to care and low utilization and optimization of available resources. These weaknesses lead to undesirable health outcomes at the community level of service delivery. Addressing these barriers and integrating community health as a cornerstone of the overall health system is a continued priority for USAID and its partners in Kenya. Kenya's Community Health Strategy (KCHS), developed in 2006, and its subsequent revisions (KCHS 2020- 2025 in the process of being finalized), is now part of the Kenya Health Policy 2014-2030. Within the Kenya Essential Package for Health (KEPH), which defines six levels of healthcare service delivery, Level 1 refers to community health services delivered via the CHS, thus situating community health as the foundational level of the health system. Under the GoK priority interventions of Universal Health Coverage (UHC) community services are viewed as the key game changer in the health sector and an essential component of achieving UHC. As a result, the community health systems have received high attention from both GoK and its development partners as well as the private sector. Recently, Kenya has been a priority country within the Integrating Community Health (ICH) collaboration, a catalytic partnership among USAID, UNICEF, and the Bill and Melinda Gates Foundation (BMGF), which has worked to advance systems thinking for primary health care at the community level and institutionalize community health within health systems. Within the ICH collaboration, activities have strengthened national coordination for improved quality of community health programs; increased capacity to prioritize and budget for community health programs using an equity approach for improved service availability; and improved the quality of care and to strengthen community engagement in community health services. This activity seeks to build upon this work.

In a developing country like Kenya, where health systems need to optimize resource use and expand population coverage, the process of improvement and scaling up needs to be based on sound local strategies for quality so that the best possible results are achieved from new investment.

Barrier: weak community health systems at national and county level affecting delivery of quality, equitable and cost-effective services especially those related to HIV&TB RMNCAH, nutrition and malaria to the community.

The recipient should suggest strategies to strengthen community health systems at national and county levels of government, based on a three-pronged approach as described below

Output 3.1: Strengthened health systems for improved quality of community health services

The activity is expected to implement strategies to improve the quality of community health interventions. The proposed health systems interventions should result in community level interventions especially those related to HIV/AIDS, RMNCAH, and malaria burden of disease at community level. The recipient is expected to work closely with the service delivery Activities, as these system-strengthening activities should impact, and support services being provided within communities.

Illustrative outcomes should include but not limited to:

- Strengthened community workforce training i.e., pre-service and Inservice
- Strengthened supervision and performance management systems for community health workforce
- Strengthened processes of establishing implementation standards and norms of community health services
- Strengthened systems of ensuring availability of commodities, supplies and tools (e.g data collection tools and tape measures) at the community level
- Strengthened community health information systems and community engagement processes for monitoring and evaluation of community services to enable rapid learning and adaptive change and ensure that community feedback and accountability systems are developed and embedded into the health system for sustainability

Output 3.2: Strengthened community health systems for enhance equitable distribution of services

The recipient is expected to implement strategies for improved equitable distribution of community health interventions based on needs, especially those aligned to HIV/AIDS, Family health and malaria disease burden. These strategies should address known existing inequalities which include but are not limited to: distribution of community health units based on disease burden and needs; establishment and strengthening of village health committees across board to enhance community voice for their own care; improved or revised resources allocation to enhance equitable distribution of community services across and within counties; and also recognition and ownership of community health volunteers and lay cadres within formal HRH systems. The recipient should also suggest measurement approaches for identifying and delineating known and additional potential inequities, before proposing approaches to address them. The illustrative outcomes for this intervention should include but not limited to:

- Strengthened use of community health data for decision making at national and county levels
- Enhanced engagement with donors and stakeholders, including local partners and community members, to align available community resources through co-creation and co-implementation processes
- Strengthened systems for enhanced and sustained community engagement in need identification, implementation and monitoring of services being delivered to support equitable access and uptake of services.
- Strengthened community health responsiveness through support to existing structures such as village committees and barazas.
- Strengthened systems to consistently monitor and adapt community health services as needed to respond to evolving needs.
- Enhanced ownership and recognition of community health workforce (cadres) by county governments, including those supported by donors.

Output 3.3: Strengthened community health systems for enhanced optimization of resources

There are weaknesses in the identification, coordination and use of available resources at the community level in that coordination of stakeholders and strategic partners remains weak, engagement of the private sector for community services is weak, mobilisation of communities to enhance ownership to enhance their contributions towards their health can go along way in enhancing sustainability towards journey to self reliance. As such there are gaps, overlaps, duplications and potential wastages which can be easily addressed by strengthening appropriate community health systems.

The recipient should suggest strategies for strengthening community health systems for optimization of available resources.

The illustrative outcomes should include but not limited to:

- Enhanced government and stakeholder coordination, for planning and budgeting of community health interventions and resources
- Strengthened coordination through joint quantification, tracking and accountability of available commodities, equipment and tools for community health services
- Strengthened local ownership of community services towards sustainability and journey to self-reliance

Relationship with other Health Investments

USAID expects that the HSSP recipients should coordinate their activities at the national and county levels, leverage on strengths and competencies, avoid duplication, and maximize on the relationships with the existing local systems to achieve a strengthened health system's common objective.

The recipient is expected to implement proposed approaches for deliberate linkage to the other HSSP Activities. As a result, this Activity is expected to coordinate with other HSSP Activities on interventions related to governance and partnerships, policy development, financing and social protection, analytics, and information systems. In addition, this Activity is intended to play a

supportive role to other HPN Activities due to its cross-cutting nature. Its interventions should be at above site level, that is, national and county levels, while other HPN interventions relating to service delivery should mainly be at site level. As a result, the Activity is anticipated to support the health systems on HRH, quality, and community health upon which the service delivery activities are intended to be relying on. The recipient should demonstrate how the proposed interventions are expected to link seamlessly with service delivery activities related to HIV/AIDS, Family Health, and Malaria for effective, efficient and synergistic results.

Partnerships

In working to achieve the overall objectives of this activity the recipient could enter into direct subaward arrangements with national and county governments as well as civil society, local development organizations, academia, research organizations, public policy think tanks, semi-autonomous government agencies and the private sector organizations. These subaward arrangements would increase the capacity and commitment of national and county governments as well as private sector organizations to mobilize domestic resources (financial, technical, in-kind) for transformational and sustainable impact.