

DRC INTEGRATED HIV/AIDS PROJECT

YEAR 2 WORK PLAN
October 2010

Contract # GHH-I-00-07-00061-00, Order No 03



LIST OF ACRONYMS

| | |
|---------|---|
| ART | antiretroviral therapy |
| BCC | behavior change communication |
| CC | Champion Community |
| CCM | Country Coordinating Mechanism |
| CDC | US Centers for Disease Control and Prevention |
| COP | Chief of Party |
| COTR | chief operating technical officer |
| CSDT | <i>Centre de Soins, Dépistage Contre la Tuberculose</i> |
| DCOP | Deputy Chief of Party |
| DRC | Democratic Republic of Congo |
| EGPAF | Elizabeth Glaser Pediatric AIDS Foundation |
| EID | early infant diagnosis |
| GBV | gender-based violence |
| GFATM | Global Fund to Fight AIDS, Tuberculosis and Malaria |
| HCT | HIV counseling and testing |
| HMIS | Health management information systems |
| HSS | health systems strengthening |
| IHAA | International HIV/AIDS Alliance |
| IR | intermediate result |
| M&E | monitoring and evaluation |
| MARP | most-at-risk populations |
| MINAS | <i>Ministère des Affaires Sociales, Action Humanitaire et de la Solidarité Nationale</i> |
| MOH | Ministry of Health |
| MONUSCO | United Nations Organization Stabilization Mission in the Democratic Republic of the Congo |
| MOPH | Ministry of Public Health |
| MSH | Management Sciences for Health |
| NGO | nongovernmental organization |
| OVC | orphans and vulnerable children |
| PEPFAR | US President's Emergency Plan for AIDS Relief |
| PICT | provider-initiated counseling and testing |
| PLWHA | people living with HIV/AIDS |
| PMU | Project management unit |
| PMEP | Performance Monitoring and Evaluation Plan |
| PMTCT | prevention of mother-to-child transmission |
| PNLS | <i>Programme National de Lutte contre le SIDA</i> |
| PNMLS | <i>Programme Nationale Multi-sectoriel de Lutte contre le SIDA</i> |
| ProVIC | <i>Projet de VIH/SIDA Intégré au Congo (Integrated HIV/AIDS Project)</i> |
| PSI | Population Services International |
| QI | quality improvement |
| SAF | Strategic Activities Fund |
| SBCC | social and behavior change communication |
| SOW | scope of work |
| STTA | short-term technical assistance |
| TOT | training of trainers |
| UNICEF | United Nations Children's Fund |

UNAIDS
UNFPA
USAID
USG
WHO

Joint United Nations Programme on HIV/AIDS
United Nations Population Fund
United States Agency for International Development
United States Government
World Health Organization

CONTENTS

| | |
|--|----|
| I. PROJECT INTRODUCTION | 5 |
| Project overview and approach | 5 |
| Project results framework | 6 |
| Project organization | 8 |
| II. YEAR 2 WORK PLAN—OVERVIEW | 13 |
| Work planning process | 13 |
| Partners and coordination | 13 |
| II. TECHNICAL ACTIVITIES BY INTERMEDIATE RESULTS | 17 |
| Intermediate Result 1: HCT and prevention services expanded and improved in target areas | 17 |
| <i>Sub-IR 1.1: Communities' ability to develop and implement prevention strategies</i> | 17 |
| <i>strengthened</i> | 17 |
| <i>Sub-IR 1.2: HCT and prevention services expanded and improved in target areas</i> | 22 |
| <i>Sub-IR 1.3: PMTCT services improved</i> | 26 |
| Intermediate Result 2: Care, support and treatment for PLWHA and OVC improved in target areas | 30 |
| <i>Sub-IR 2.1: Palliative care and Support for PLWHA strengthened</i> | 35 |
| <i>Sub-IR 2.2: Care and support to orphans and vulnerable children (OVCs)</i> | 37 |
| Intermediate Result 3: Strengthening of health systems supported | 41 |
| <i>Sub-IR 3.1: Capacity of provincial government health systems strengthened</i> | 42 |
| <i>Sub-IR 3.2: Capacity of NGO providers improved</i> | 44 |
| <i>Sub-IR 3.3: Strategic information systems at community and facility strengthened</i> | 44 |
| IV. CROSS-CUTTING ACTIVITIES | 47 |
| Monitoring and evaluation | 47 |
| Gender | 48 |
| Family planning | 49 |
| Grants management | 49 |
| Training | 51 |
| Procurement | 51 |
| Environmental compliance | 52 |
| IV. ANNEXES | 53 |
| Annex A. Detailed Year 2 activity plan (see attachment) | 53 |
| Annex B. Partner and collaboration matrix | 53 |
| Annex C. Year 2 expatriate short-term technical assistance | 66 |
| Annex D. Year 2 budget summary (all partners) | 70 |

I. PROJECT INTRODUCTION

Project overview and approach

The objective of the integrated HIV/AIDS Project (*Projet de VIH/SIDA Intégré au Congo*, or ProVIC) is to reduce incidence and prevalence of HIV and mitigate its impact on people living with HIV/AIDS (PLWHA) and their families. We will achieve this objective by improving HIV/AIDS prevention, care, and support services in selected areas; increasing community involvement in health issues and services beyond facility-level services through sustainable, community-based approaches; and increasing the capacity of government and local civil society partners—and thereby empowering new local organizations—to plan, manage, and deliver quality HIV/AIDS services. These objectives will serve to strategically link project activities to results.

Our project approach is based on the following strategies:

An integrated and innovative community-based approach

ProVIC uses the Champion Communities model as a mechanism to support communities in addressing all aspects of HIV/AIDS services, from counseling and testing and prevention messaging to palliative care and support of orphans and vulnerable children (OVCs). This approach empowers community actors to identify their needs and develop strategies to address them, both through simple actions that communities can take themselves, and through ProVIC and/or other local partners' efforts to link them to services such as HIV counseling and testing (HCT), palliative care, prevention of mother-to-child transmission (PMTCT), and support groups for OVCs and people living with HIV/AIDS (PLWHA). The project will also support communities to integrate the needs of the most at risk populations (MARPs) into their strategies by incorporating them into the community goal-setting process and developing strategies for outreach to those communities.

Sustainability through capacity-building at all levels

The project works toward sustainable interventions through a strategy of empowering local institutions to take ownership of these interventions. This is accomplished at the community level through the Champion Community (CC) approach. This participatory intervention model encourages communities to take responsibility for their health outcomes by strengthening government partners' supervision and oversight capacity, and by building the capacity of nongovernmental organizations (NGOs) and civil society partners to plan and manage HIV/AIDS interventions.

Leveraging resources through partnerships

ProVIC has also reached out to other partners engaged in HIV/AIDS work, including The Global Fund to Fight AIDS, Tuberculosis and Malaria, United Nations Organization Stabilization Mission in the Democratic Republic of the Congo (MONUSCO), United Nations Children's Fund (UNICEF), Joint United Nations Programme on HIV/AIDS (UNAIDS), United Nations Population Fund (UNFPA), Population Services International (PSI), Management Sciences for Health (MSH), and others to leverage their resources toward more integrated services at the community level. This leveraging will be critical to the success of the integrated, community-based model, increasing communities' and beneficiaries' access to a fuller array of services than those that ProVIC can offer. More on coordination and partnering is in Annex B.

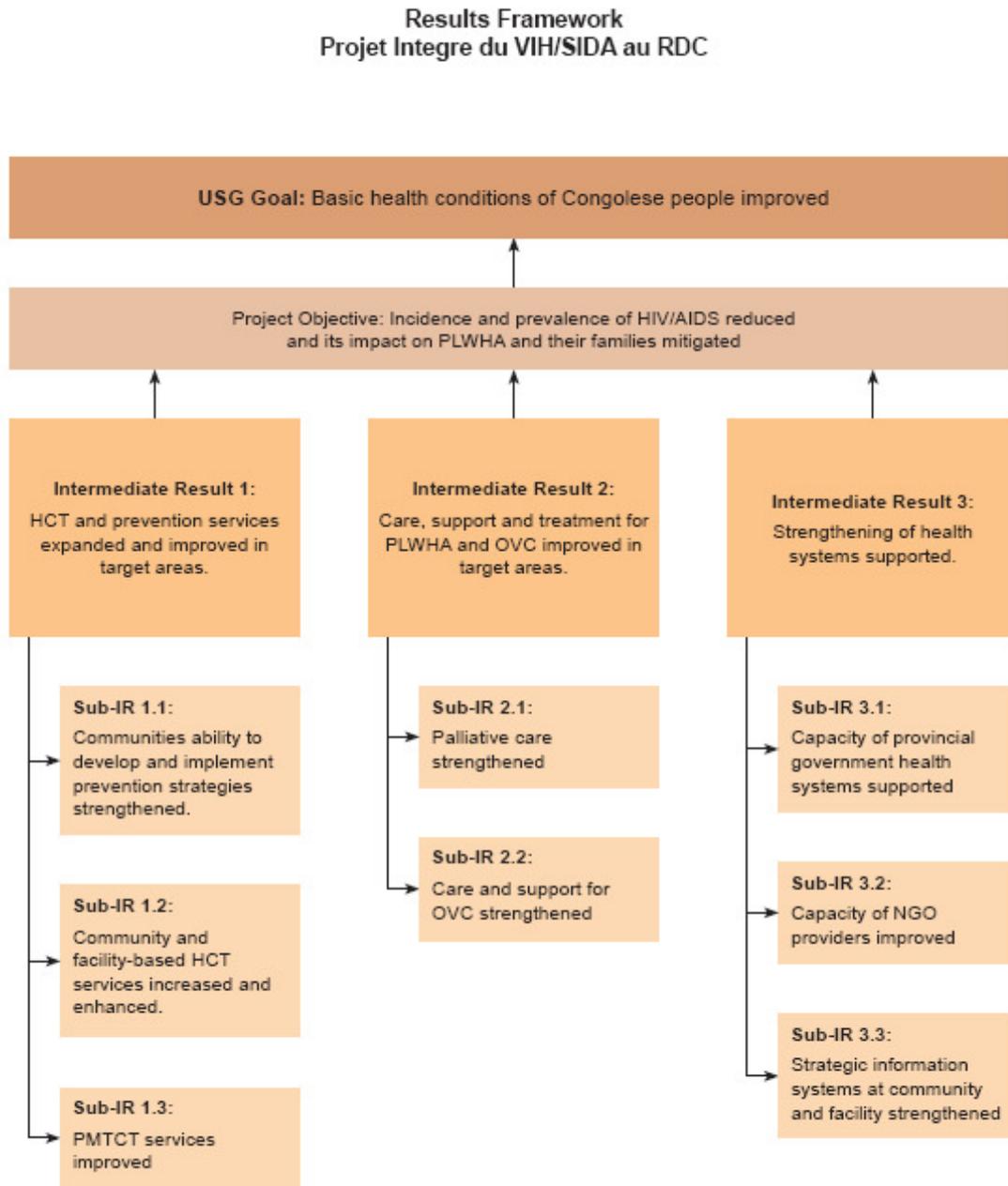
Project results framework

ProVIC's project objectives have been mapped according to a Project Results Framework, our planning, communication, and management tool. Per the project's scope of work and objectives as outlined by USAID, we have developed three intermediate project results that will together contribute to achieving the overall project objective. The project objective, in turn, contributes to the US Government's overall strategic goal of improved basic health conditions for the Congolese people.

The Project Results Framework depicts both the project's development hypothesis and causal relationship between sub-intermediate results (sub-IRs) and intermediate results (IRs). It also demonstrates how the project intends to reach its overall objective through achievement of its three intermediate results. We believe that improving and expanding HCT and HIV prevention services (IR 1), improving care, support, and treatment for PLWHA and OVCs (IR 2), and supporting health systems strengthening (HSS, IR 3) in target areas will together generate the highest-level outcome—namely, the project's objective to reduce incidence and prevalence of HIV/AIDS and mitigate its impact on PLWHA and their families.

To support achievement of each of three, higher-level or *intermediate* results, we have strategically organized project activities into *sub-intermediate* results. Beyond providing an organizational framework for project activities, the Project Results Framework serves to programmatically link the work plan with the Performance Monitoring and Evaluation Plan (PMEP). For each intermediate result and supporting sub-intermediate result, we have established specific measures, or indicators, and targets and determine how to collect, analyze, and share data and other information. The PMEP will accurately and directly measure the project's progress toward results. Figure 1 on the following page illustrates ProVIC's Project Results Framework.

Figure 1. ProVIC Project Results Framework



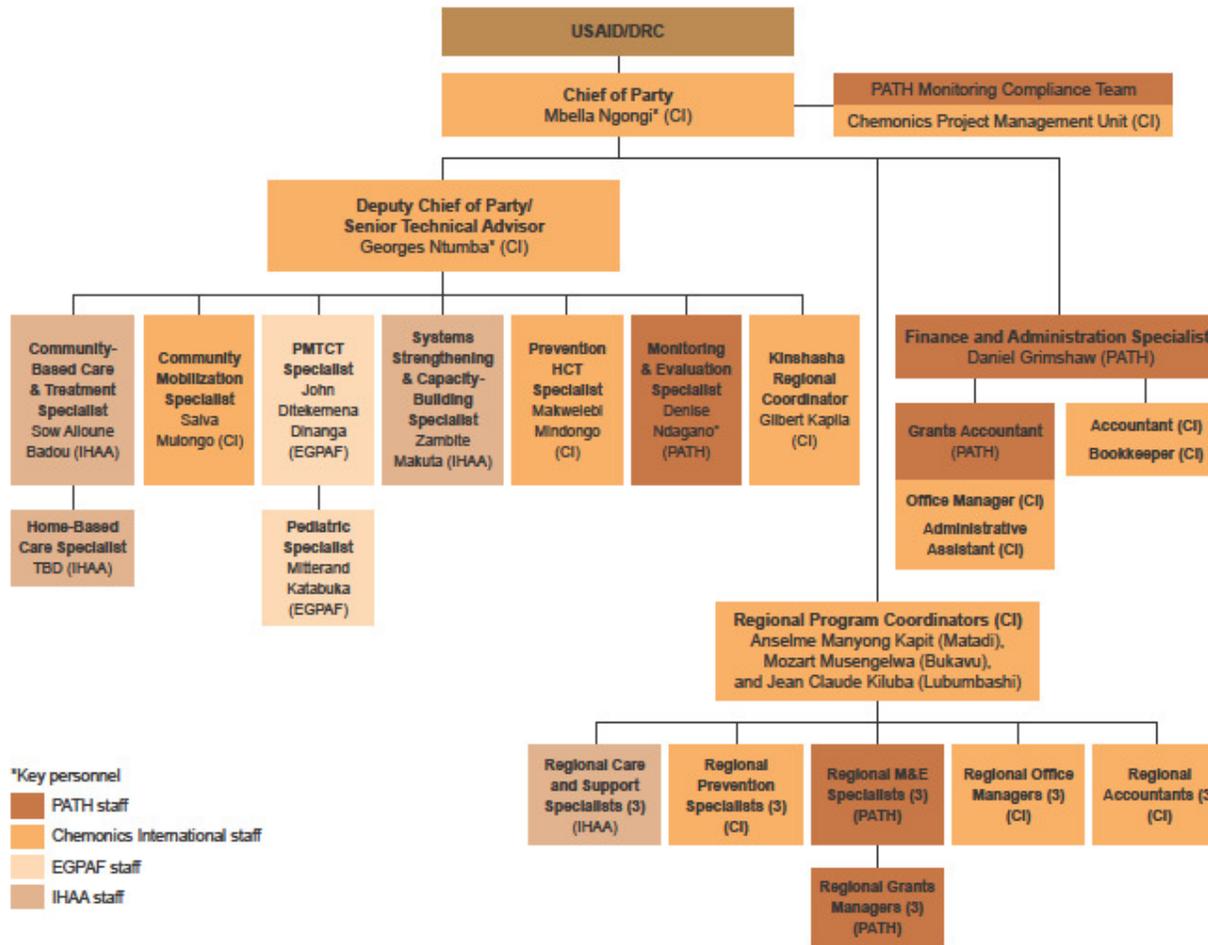
Project organization

Organizational structure and management

ProVIC has been structured to strategically implement activities and achieve results in four targeted project zones, with the Kinshasa office providing overall supervision and management. The Chief of Party (COP) and Deputy Chief of Party (DCOP) oversee the project strategy and activity design and integration and ensure that targets and results are met. Technical specialists in Kinshasa develop project strategies and activities in their respective areas, monitoring these activities across the four regions.

The three regional offices in Matadi, Lubumbashi, and Bukavu are each headed by a regional coordinator, who supervises technical specialists in prevention, care and support, and monitoring and evaluation (M&E). These specialists receive guidance and input from the technical specialists in Kinshasa. Each office is also supported by a grants manager and administrative staff who can manage the funding of partners in that area. Kinshasa regional activities are overseen by a Kinshasa regional coordinator, with support and input from the Kinshasa-based technical specialists. The project team is therefore structured as a single, streamlined, operating unit benefitting from the integrated expertise of all project consortium members. All staff report to their respective project supervisors as appropriate (e.g., COP, DCOP, finance and administration specialist or regional coordinator), regardless of employer, and plan and implement their activities according to the project work plan. Staff roles and responsibilities are detailed in Figure 2 and in Table 1 on the following pages.

Figure 2. ProVIC staffing organigram



The project is supported and managed by the home-office resources of all four consortium members. As the prime, PATH provides overall project management, compliance monitoring, and targeted technical support in areas such as grants, M&E, and gender. Nathalie Albrow, Senior Program Manager, with support from M&E specialist Anh Thu Hoang, and program administrator/assistant Nefra Faltas, leads PATH's home office team in these oversight activities. PATH also supervises all subcontractors, ensuring their satisfactory and timely completion of deliverables and compliance with project requirements.

Consistent with the original project design, Chemonics is leading the project's field implementation efforts. The project's COP and DCOP, as well as the project's regional coordinators and most administrative and support staff, are Chemonics employees. Chemonics' budget supports most project operations in the field, from providing technical oversight in the areas of HCT and community mobilization to coordinating closely with PATH on all aspects of implementation. The COP also keeps PATH informed through regular email and Skype communications and a weekly teleconference that includes the field office senior management and Chemonics and PATH home office staff. Chemonics' project director Kathryn Goldman, project manager Martha Larson, and project associate Isabelle Mulin backstop the field team with technical and managerial support and coordinate closely with PATH on all aspects of project implementation.

PATH and Chemonics value clear communication with USAID through both the field-based and home office teams. The COP will continue to work closely with USAID through the contracting officer technical representative (COTR) and other USAID health technical staff, so that USAID is informed of project strategy and activities and is providing regular input where needed. In addition, PATH's senior program manager Nathalie Albrow will coordinate bi-monthly telephone check-ins with the COTR to discuss project implementation and any issues to be addressed. Ms. Goldman and Ms. Albrow plan two supervisory visits per year to ensure that the project is meeting its targets, provide supervision to staff, and contribute to work planning as needed.

ProVIC's two other consortium partners, The International HIV/AIDS Alliance (IHAA) and Elizabeth Glaser Pediatric AIDS Foundation (EGPAF), provide valuable technical assistance and oversight in their core technical areas, with IHAA supporting the care and support component and health systems strengthening (HSS) activities and EGPAF supporting PMTCT activities. These partners offer technical guidance to their supported staff through regular phone and email check-ins, short-term technical assistance (STTA), and supervisory visits as needed. All partners contribute to annual work planning and report development, with their technical support coordinated through the COP and through PATH's and Chemonics' home offices to ensure its alignment with the project strategy and work plan.

Table 1. ProVIC staff roles and responsibilities

| Position | Name | Roles and responsibilities |
|--|-------------------------------|--|
| Chief of Party | Mbella Ngongi | <ul style="list-style-type: none"> • Provide technical direction and management oversight for program activities. • Supervise technical and administrative staff. • Liaise with USAID and Democratic Republic of Congo (DRC) government. |
| Deputy Chief of Party/Senior Technical Advisor | Georges Ntumba | <ul style="list-style-type: none"> • Oversee technical team. • Lead integration and implementation of project’s technical strategy. |
| Community-Based Care and Support Specialist | Alioune Badara | <ul style="list-style-type: none"> • Responsible for technical design and supervision of care and support component. • Works with consultants, IHAA resources, and other project staff to design and implement care and support interventions for PLWHA and OVCs. • Provides technical support to regional care and support specialists. |
| Home-Based Palliative Care Specialist | TBD (recruitment in progress) | <ul style="list-style-type: none"> • Supports community-based care and support specialist in designing and implementing palliative care clinical interventions to meet PLWHA’s and OVCs’ medical needs (e.g., in facilities or through home-based care). |
| Community Mobilization and Gender Specialist | Salva Mulongo | <ul style="list-style-type: none"> • Responsible for technical design and supervision of Champion Communities (CC) approach in IR 1, and in integrating gender across all components. • Works with consultants, Chemonics resources, and project staff to design and implement CC approach. • Works with STTA to design and integrate the gender strategy across all project IRs. • Provides technical support to regional prevention specialists in community mobilization. |
| PMTCT Specialist | John Ditekemena Dinanga | <ul style="list-style-type: none"> • Responsible for technical design and supervision of PMTCT activities under IR1. • Works with consultants, EGPAF resources, and project staff to design and implement PMTCT activities. • Provides technical support to regional prevention specialists in PMTCT. |
| Pediatric Specialist | Mitterand Katabuka | <ul style="list-style-type: none"> • Responsible for providing technical assistance to all pediatric care and treatment activities. • Oversees activities, including identifying gaps in pediatric care and treatment, helping to link pediatric care and treatment to PMTCT activities, working with other implementing agencies, and coordinating training for clinical staff. |
| Systems Strengthening and Capacity-Building Specialist | Zambite “Elyse” Makuta | <ul style="list-style-type: none"> • Responsible for technical design and supervision of HSS and capacity-building activities under IR3. • Works with consultants, IHAA, Chemonics resources, and project staff to design and implement HSS and capacity-building activities. • Provides technical support to regional program coordinators in HSS and capacity building. |

| Position | Name | Roles and responsibilities |
|---------------------------------------|--|--|
| Prevention and HCT Specialist | Voulu Makwelebi Mindongo | <ul style="list-style-type: none"> • Responsible for technical design and supervision of HCT activities under IR-1. • Works with consultants, Chemonics resources, and project staff to design and implement HCT activities. • Provides technical support to regional prevention specialists for HCT activities. |
| Monitoring and Evaluation Specialist | Denise Ndagano | <ul style="list-style-type: none"> • Responsible for collecting and analyzing project data and assisting in reporting and communicating project results. • Provides technical assistance and support to regional M&E specialists and contributes to strengthening data collection at community, facility, and provincial government levels. |
| Finance and Administration Specialist | Daniel Grimshaw | <ul style="list-style-type: none"> • Supervises grants, finance, and administrative staff to ensure compliance, oversight, and smooth implementation. |
| Office Manager | Francine Ngoy | <ul style="list-style-type: none"> • Responsible for smooth functioning of office, including personnel management, logistics, procurement, travel, motorpool, and other administrative duties. |
| Accountant and Grants Accountant | Tryphon Mbadinga, Christian Mukenge | <ul style="list-style-type: none"> • Maintains project financial records and accurately books all transactions. • Ensures all grants and direct support transactions are booked and justified through appropriate backup documentation. |
| Regional Program Coordinators | Gilbert Kapila, Mozart Musengelwa, Jean Claude Kiluba, Anselme Manyong Kapit | <ul style="list-style-type: none"> • Coordinates all technical assistance within respective region, supervision and guidance for regional technical specialists, and supervision and management of the regional administrative team. • Will implement HSS/capacity-building activities under IR-3. |
| Regional Care and Support Specialists | Alexandre Kabanga, Fidele Kanyanga, Emmanuel Mpanzu | <ul style="list-style-type: none"> • Provides technical oversight for care and support component, IR-2, at regional level by supervising design and management of grants program for care and support of PLWHA and OVCs. • Provides direct technical assistance and training to partners in project approaches under IR-2. |
| Regional Prevention Specialists | Astrid Mulenda; Lydia Kabamba Mulongo; Chanty Mombo | <ul style="list-style-type: none"> • Provides technical oversight of prevention component, IR-1, at regional level by supervising implementation of HCT, CC, PMTCT, and other prevention activities. • Supervises design and management of grants program in HCT and community mobilization. • Provides direct technical assistance and training to partners in project approaches under IR-1. |
| Regional M&E Specialists | Venant Zihahirwa Antoine Mafwila Enoch Mananga | <ul style="list-style-type: none"> • Collects M&E data at regional level from project grantees, beneficiaries, and staff. • Provides training and capacity-building support to grantees, partners, and staff in developing M&E plans, and collecting and data. • Works with Kinshasa M&E specialist to design M&E capacity-building interventions for provincial government and partners. |
| Regional Grants Managers | Benjamin Metre Teddy Kalema Fabien Bikoko | <ul style="list-style-type: none"> • Oversees grants process at regional level, including coordinating application process with potential grantees, providing feedback, handling budget negotiations, and managing grant award disbursements and follow-up. |

| Position | Name | Roles and responsibilities |
|--------------------------|---|--|
| Regional Office Managers | Desire Mukambilwa, Vincent Yabwana, Fabien Bikoko | <ul style="list-style-type: none"> • Manages project office’s administrative functions at regional level. |
| Regional Accountants | Arlette Santono, Jean Heri Burale, Justin Kapuku | <ul style="list-style-type: none"> • Manages project’s financial functions at regional level. |

II. YEAR 2 WORK PLAN—OVERVIEW

Work planning process

Year 2 work planning was completed using the same collaborative process that was used in year one. ProVIC convened a planning workshop from September 20-24, 2010 that included project technical staff including representatives from regional offices and representatives from the home offices of PATH, Chemonics, IHAA, and EGPAF. The workshop included team-building sessions, analysis of Year 1 from a technical and management perspective, and discussions of overall project strategy and results. USAID staff also attended one morning and made a presentation about their expectations for the project during Year 2. Technical staff developed presentations outlining their overall strategy and approach, Year 1 accomplishments, and planned activities and expected results for Year 2 in terms of PMEP targets. Each component was discussed by the full team, and participants were given the opportunity to discuss the details of implementation.

The team devoted particular time to discussing how to accelerate implementation of the CC approach and integrate this approach with all other project components. Sessions were also devoted to discussing project M&E, developing updated targets for Year 2 and Year 3, project finance and budgeting practices, and next steps pertaining to the grants process. Regional coordinators presented the situation in their respective regions and facilitated a discussion on the best strategy moving forward for selecting grantees who meet the team’s criterion of identifying fewer partners per region with the capacity to quickly implement multiple interventions—particularly using community mobilization as a foundation.

Following the workshop, staff worked with their respective headquarters teams in developing their work plans, revised M&E targets, and budgets. These revised work plans were then presented to a core group of project stakeholders, including PNLs, PNMLS, MINAS, UNICEF, and others. Individual staff members made visits to other critical partners for their particular technical areas so that the work plan could be shared and commented on.

Partners and coordination

ProVIC presents exciting challenges and opportunities to building partnerships and ensuring effective and efficient coordination in order to bring about and build synergies across and within broad-ranging groups of actors at the national and provincial levels.

Government agencies, international multi-lateral and bilateral donor agencies, local and international NGOs, community-based organizations, politicians, the private sector, other USAID-financed health programs and projects, and a wide range of civil society groups, among others, are involved, directly or indirectly, in ProVIC’s activities. In order to leverage

existing and new human and financial resources, collaborate more effectively with this broad array of important players in the field, and ultimately achieve our project's results, it is imperative that our project harmonize various agendas and reprioritize objectives where there is discordance.

A complex mix of international donors, NGOs, churches, government agencies, members of the private sector, and individual citizens are engaged in various aspects of the fight against HIV/AIDS. However, one common, negative, factor characterizing their field interventions is their lack of effective and efficient coordination and oversight. This weakness has resulted in inefficiencies and duplication of programming efforts, with all the attendant waste and misuse of valuable, limited human and financial resources.

Some promising, laudable efforts have been recorded in the attempt to mitigate some of the negative effects of this situation: regular meetings of the "Groupe Inter-Bailleurs Sante"; Signing of memoranda of understanding between the government and donors; and the creation of some service-specific task forces at the central and provincial levels, have all helped improved the situation. Despite these efforts, much work remains to create an enabling environment that promotes and supports the building of partnerships and ensuring partner collaboration in a country so divided by internecine conflict, ethnic and other differences, and diverse interests, local and international.

In Year 2, the ProVIC project will build on the relationships and partnerships developed during the first year and leverage on these existing partnerships to expand to new, key, relevant and willing partners at both the national, provincial and grassroots levels. We will also seek to establish practical collaboration and partnerships first by identifying those partners with whom we share commonalities. In doing so, we will identify various areas of convergence with central and provincial government agencies, multi-lateral and bilateral donor agencies, civil society and community based organizations and the private sector.

Our collaborative approach will be to emphasize regular communication with key stakeholders, encourage and promote transparency, share our work plans and encourage the preparation of joint work plans, where possible and appropriate, and in seeking stakeholder and partner feedbacks in our planning process. Our guiding principle will be to align our program activities and systems with national strategies, policies and protocols.

As we launch and scale up our innovative, exciting Champion Communities model around which most of our program's activities will be centered, we will capitalize on the partnerships, collaboration, and coordination mechanisms we promote at all levels to win its acceptance, support and appropriation at all these levels. At the national government level, advocacy and sensitization efforts have been launched with the leadership of key partners such as PNMLS, The Prime Minister's Office, the Ministry of Health, PNLS, the Ministry of Social Affairs, the Ministry of Gender and the Family.

At the provincial level, advocacy efforts to win the commitment of the provincial governments to this new strategy have begun and are ongoing. In Bas Congo, one-on-one meetings were held in August and September 2010 with the Governor's representative, Minister of Health, Social Affairs, Justice and Human Rights, PNMLS, and PNLS. These initial meetings were held in preparation for a larger, town hall-like meeting in which the Champion Communities model would be introduced and explained to provincial government partners and other key stakeholders and provincial representatives of key stakeholders in the

national capital. In Katanga, meetings have been held with the Governor, Minister of Health, Minister of Social Affairs and Gender and Family, and other members of the government leadership, also in preparation for a larger, town hall-like meeting at which a more detailed presentation of the CC model would be given to key stakeholders. In Sud Kivu, similar meetings have been scheduled with the Governor, members of his cabinet, and other key stakeholders. Similar preparations are underway in Kinshasa.

In parallel to these advocacy efforts at the national and provincial government levels, we have already started engaging key international donor agencies and partners such as UNAIDS, UNICEF, UNDP, MONUSCO, ILO, UNFPA, Global Fund, and others, some of whom have provincial representatives in our four intervention provinces. Aside from individual presentations of our innovative approaches through the Champion Community model, we also plan to deliver day-long presentations to a larger representation of multi-lateral and bilateral donors and stakeholders, particularly those with whom we intend to build synergies and close collaborations in the field.

Alongside with these partnership-building efforts and coordination, ProVIC has planned and will execute implementing partner-specific training sessions for approximately 13 pre-selected grant award finalists, whose mission will be to work with the 40 champion communities identified in Year 2.

More specifically, the project will work in close collaboration with the following key partners, for whom a detailed table of collaboration is included in Annex B:

US Government partners:

- PSI
- C-Change
- MSH/SPS
- H/S 20-20
- University of North Carolina/Kinshasa School of Public Health
- MSH
- PATH-TB 2015
- CDC

Other donors and international partners:

- UNAIDS
- UNICEF/Village Assaini
- UNFPA
- Global Fund
- The World Bank
- UNIFEM
- UNDP
- MONUSCO
- WHO
- ILO
- WFP
- FAO
- Other bilateral donors

National-level DRC government partners:

- PNMLS—Presidency of the Republic
- PNL—Ministry of Health
- Ministry of Social Affairs
- Ministry of Gender and the Family
- Ministry of Education and Vocational Training

Provincial-level DRC government partners:

Bas Congo

- Governor
- Ministries of Health, Agriculture and Gender, and Education
- PNMLS
- PNL
- Ministry of Health, Social Affairs, Justice and Human Rights
- Mayors and Chefs de Cite in Champion Community sites

Katanga

- Governor
- Ministry of Health
- PNMLS
- PNL
- Ministry of Social Affairs, Gender and Family
- Ministry of Lands
- Mayors or Chefs de Cite in the CC sites

Sud Kivu

- Governor
- Ministry of Health
- Ministry of Social Affairs
- PNMLS
- PNL
- Mayors or Chefs de Cite in CC sites

Kinshasa

- Governor
- DIVAS
- Ministry of Health
- PNMLS
- PNL
- Mayor and/or “Bourgemestre” in CC sites

NGOs and community-based organizations

- 10-13 local NGOs in 4 project provinces
- Women’s, youth, and men’s clubs and groups
- Specific groups, e.g., MSM

Public-private partnerships

We will build public-private partnerships and actively collaborate with private establishments, such as:

- Telephone companies—Tigo, Vodacom, Zain
- Breweries—Bralima, etc.
- Trading companies—Congo Futur
- Financial establishments—SOFICOM, Raw Bank, Ecobank, BCDC, etc.
- Mining companies
- Airlines (local and international)
- Supermarkets—REGAL, Peloustore
- Research institutions, universities, and vocational and other specialized schools

II. TECHNICAL ACTIVITIES BY INTERMEDIATE RESULTS

This section outlines in detail activities to be completed under each corresponding intermediate result (IR) and sub-intermediate results (sub-IRs) per our results framework. We have also included milestones for each sub-IR that will be tracked over the course of the year. The descriptions below are complemented by Gantt charts which show the timeframe for activities in graphical form. The Performance Monitoring and Evaluation Plan will have the detailed indicators by IR and sub-IR.

Intermediate Result 1: HCT and prevention services expanded and improved in target areas

Overview and strategy

In order to expand and improve HCT and prevention services in project-targeted zones, we propose the following three sub-intermediate results (sub-IRs):

Sub-IR 1.1: Communities' ability to develop and implement prevention strategies strengthened

Sub-IR 1.2: Community-based and facility-based HCT services enhanced

Sub-IR 1.3: PMTCT services improved

We recognize that generating the intended result requires focusing activities and strategies on strengthening the ability of communities to implement effective prevention strategies, enhance and increase access to HCT services at both the facility and community levels, and support improved PMTCT services. Descriptions of activities planned for Year 2 are provided for each sub-intermediate result below.

Sub-IR 1.1: Communities' ability to develop and implement prevention strategies strengthened

Overview and strategy

The Champion Community model is a participatory one, designed to mobilize and engage communities to define and undertake specific actions aimed at achieving or improving their health, social or economic status. It involves active and informed participation of the whole community in identifying health and development issues, determining objectives or results to be achieved, implementing specific actions, and monitoring the implementation and public and collective enjoyment of concrete benefits or outcomes. The approach also empowers

communities, focuses on their internal strengths and weaknesses, mobilizes local resources, and develops mechanisms for attracting external resources.

Applying this approach to the ProVIC project underscores the importance of community engagement to the success of all project interventions. Fostering champion communities will help increase demand for services such as HCT, PMTCT, and palliative care, critically link the project with MARPs and other vulnerable groups, and lead to more sustainable interventions as activities are planned and implemented through community mechanisms. This is particularly true of care and support activities, some of which will be coordinated through CC partners.

In the context of HIV/AIDS, the Champion Community approach stresses and capitalizes on the importance of the community in the local response to HIV/AIDS. It empowers communities to demand, access, utilize and support existing HIV services: HCT/prevention, PMTCT, care and support for PLWHA and OVC, home-based care, and other nutritional support. It is based on the engagement and involvement of individuals, families, communities, associations, NGOs, civil society, and business community to create dynamics that boost local participation in the planning, implementation, and monitoring and evaluation of local responses to HIV/AIDS. The model increases and reinforces the capacity of the communities to effectively respond to HIV/AIDS and mitigate its impact, develop community leadership in demanding quality services, establish strong linkages between communities and service delivery points, and leverage existing services to meet community needs.

The model is also designed to promote gender equity by integrating both men and women in program activities, providing and facilitating access to family planning services and techniques, transforming social norms, practices and behaviors that promote discrimination, marginalization and stigmatization of vulnerable persons and groups. In addition, it helps communities develop their own internal mechanisms for providing sustainable assistance and support to PLWHA, OVCs, and families affected by HIV/AIDS. In this way, ownership of both the process and outcome lies with the community itself.

This seven-step process starts with the mobilization of and advocacy with political, religious, community, business, civil society, and government leaders. The second step consists of organizing the community into steering committees that include representatives of various population and interest groups from different levels of the communities including PLWHA. Step three involves building the capacity of steering committee members and community volunteers to identify problems, define priorities, negotiate objectives, develop action plans, and sign an agreement supporting their plan. The fourth and fifth step are the effective implementation of these plans, and regular monitoring and follow up of the activities of community volunteers by the M&E specialists and implementing partners (monitoring ideally takes place at the 100 and 200 day marks). The sixth step is a self-evaluation and validation of the evaluation report to measure whether targets have been achieved. The seventh and last step is a celebration of the achievements with rewards and incentives that benefit the whole community.

During Year 1, ProVIC was able to bring in a Malagasy consultant to help the project staff understand the champion communities approach and modify it to be responsive to the DRC and ProVIC context. As part of that process a detailed implementation manual was developed along with guidelines for how to integrate the model into this specific project and its

components. Though the project experienced delays in getting the model off the ground, ProVIC staff did accomplish some of the critical advocacy at the national and regional level to help government and civil society leaders understand the benefits of the approach and the plan for implementation. In addition, project staff began some pilot activities by identifying one community in each region that met the criteria and beginning the initial steps with those communities in terms of forming the committees and identifying issues. These steps will be built upon in this year as the model is more fully and completely rolled out.

In order to ensure a smooth and effective roll out of the model in 40 selected sites, NGOs with strong ties to communities will be identified, capacitated and provided with grants to lead the process and operationalize the 40 champion communities. It is important to note that this cycle should take no less than 9 months and typically runs its course in 12 months. Therefore, we expect that by the end of Y2 we will be approaching the last step of the cycle, but that the actual celebration and recognition of the community's achievements will actually occur in the first quarter of Year 3.

Activity 1: Complete the process of adapting and validating the Champion Communities approach for the DRC

Dr. Salva will work with government partners such as PNMLS, PNLS, and MINAS to present, discuss and adapt the CC model so that the manuals and implementation documents prepared by the consultants in Year 1 are fully accepted and validated by critical government partners. They will also help identify other potential partners doing community mobilization who should be consulted or implicated in implementation. Dr. Salva will present the approach along with the detailed operational manual developed in year one to all these partners for their feedback through a one day workshop in October 2010. Following the workshop, all comments will be incorporated into project implementation documents.

Activity 2: Finalize the selection of NGO partners who will implement the approach

Through the year one RFA and grants application process as well as from experience working in each region, ProVIC staff were able to identify a set of NGO partners in each region who have the capacity to do the kind of community mobilization work required for champion communities, who have experience working with community groups including those most at risk for HIV, who have links and experience with health services in their area, and who have the possibility to identify and mobilize communities over several targeted health zones. These partners will be given the updated terms of reference for champion communities and will participate in a briefing session to clarify and discuss how they will add champion communities to their existing activities. Dr. Salva and an international CC consultant will then assist these partners in developing their proposals and implementation plans. Their proposals and budgets will be analyzed to ensure they meet the implementation, and they understand the approach, and this will lead to the signing of one year grant agreements for this year. We expect this process to be complete between November 2010 and December 2010.

Activity 3: Organize the baseline study in Champion Community areas

Dr. Salva and the ProVIC M&E team, with support from PATH's DC-based M&E specialist Anh Thu Hoang, will use existing CC tools and guides, including those developed by Dr. Rija Fanomezwa in Year 1, to create a baseline questionnaire that can be used in our CC sites and meets the needs of ProVIC in terms of information gathering on existing HIV services offered in the community, the conditions of accessibility for these services, the level of

utilization of these services by the community, and how PLWHA and OVCs are supported by the community and their families. This information will be collected by our implementing partners, with researchers recruited from the community itself, and will provide a baseline for comparison post-intervention.

Activity 4: Develop tools and materials for implementation of champion communities

Dr. Salva and a CC consultant will take stock of all the tools and materials that exist on champion communities during the first quarter of Year 2. In collaboration with ProVIC systems strengthening specialist, they will then develop training modules for CC partners. They will also develop other requisite implementation tools, such as the list of objectives the community can choose from, M&E partner tools, and other required documents.

ProVIC will also consider whether a study tour to Madagascar for certain key implementers of the approach would be beneficial in terms of developing the detailed implementation plan and materials.

Activity 5: Train partners in the Champion Community approach

The training of partners will be done during the first quarter. For this training, ProVIC will engage an international consultant, likely Dr. Fanomezana, who developed the CC materials in Year 1 to co-facilitate a workshop for ProVIC partners and staff on how to implement the Champion Community approach. This training will account for different project components and how they are linked to champion communities. It will also include sections on community gender dynamics, as well as gender empowerment approaches to be incorporated. Pending final determinations related to dates and cost, we plan to conduct two trainings—one for partners in the west (Kinshasa and Matadi) and one for those in the east (Bukavu and Lubumbashi).

Activity 6: Develop behavior change communication materials

Because changing behaviors in relation to HIV/AIDS is one of the primary goals of champion communities, ProVIC will adapt existing materials and behavior change communication (BCC) tools as needs are identified by partners and communities. This may include materials to encourage counseling and testing, improve male involvement in PMTCT, reduce stigma and support PLWHA, and help the community support OVCs. ProVIC will work closely with C-Change and PSI to identify key messages and develop tools such as brochures, posters, flip charts, training guides, and radio messages. These tools will be produced and disseminated among all champion communities using appropriate and US Government-compliant branding and marking.

Activity 7: Reinforce the capacity of implementing partners in social and behavior change communications (SBCC)

ProVIC will work with C-Change to organize a capacity-building workshop in SBCC for partners involved in the implementation of champion communities activities and those from government entities such as PNLs, PNMLS, MINAS, and the Ministry of Gender and Family. The trainees will be oriented to adult education methodology and techniques to allow them to conduct cascade training in their respective provinces and champion communities. In this way, NGO implementing partners, and in turn, champion communities, will have developed skills in identifying partners, and in turn, champion communities, will have developed skills in identifying and developing messages critical to the behavior change sought by the community.

Activity 8: Support implementation of champion communities in 40 sites

Dr. Salva and the regional prevention specialists will ensure the availability of all champion community tools and materials to all regional offices and NGO implementing partners.

The process of supporting the implementation of 40 champion communities will be based on the following steps:

1. Determination of potential aires de santé and sites to be transformed into champion communities based on specified criteria: geographical accessibility, 40,000 inhabitants, presence of health structures, particularly those supported by ProVIC, offering HIV/AIDS services, community willingness, engagement and capacity to be involved in activities to fight HIV/AIDS.
2. Constitution of steering committees made up with representatives from different interest groups and categories of the population including people living with HIV/AIDS. After meeting with community leaders and the introduction of the CC approach, NGO implementing partners with the assistance of community members facilitate the process of identification of individuals with stature to become members of the steering committee. The potential members are elected or endorsed by community members to become sitting members of the steering committee.
3. Development and reinforcement of the capacity of steering committee members. Training will be conducted by members of NGO implementing partners who have previously trained as trainers in the CC approach. The agenda will include topics such as strategic and operational planning; leadership; public advocacy; gender equity and equality; BCC; resource mobilization; and monitoring and evaluation in relation to HIV/AIDS.
4. Identification and training of community volunteers and peer educators. Community volunteers and peer educators will be selected or designed by the steering committee in consultation with different and various interest groups and associations. Each interest group or association will designate two representatives to be trained by implementing partners as peer educators or community champions. An incentive system that provides special status to community champions will be determined with the input from the community itself. Kits containing communication tools and materials for BCC will be supported by the program to serve as a factor for boosting the visibility of the program and also as a motivation factor for the peer educators.
5. The implementing partners will assist steering committees at each step of the process and will ensure stated goals and objectives are being met and results are being produced in a timely manner and under the limit of the available resources.

A roadmap that describes the whole process of implementing the CC approach will be made available to implementing partners, with specific activities and deliverables expected at each step of the process. This will include a town hall-like community meeting, to be convened by the steering committee to analyze the prevailing situation in relation to HIV/AIDS and other development issues, identification of needs, determination of priorities, development of an action plan and a plan for monitoring and evaluation.

To ensure effective implementation of social mobilization and awareness activities in champion communities, ProVIC will engage PSI and C-Change in planning activities such as site visits, distributing condoms, and organizing video forums. With support from our M&E

team, we will ensure monthly supervision of project sites in collaboration with the regional prevention specialists, as well as regional coordination of PNLs activities.

Lastly, Dr. Salva, implementing NGOs partners, and PNLs will conduct joint, formative, and supervisory site visits every three months. These supervisory trips will help identify gaps to then be addressed through an action plan aimed at improving ProVIC champion communities' performance.

Year 2 project milestones

- Validation of the Champion Community approach by key partners.
- Identification of NGO partners who will implement the approach.
- Collection of baseline data from champion communities.
- Complete development and dissemination of tools and materials for implementation of champion communities.
- Completed training of NGO partners in CC approach.
- Adaptation, production, and distribution of BCC materials.
- Creation and training of 40 CC committees.
- Development of action plans for each CC.
- Regular support and follow up by partners and ProVIC staff underway.

Sub-IR 1.2: HCT and prevention services expanded and improved in target areas

Overview and strategy

In Year 2, ProVIC will continue to provide providing quality services in line with the National Strategy against HIV/AIDS and based on client needs. The project will provide three types of HCT services. At the community level, our partners will use mobile units to provide HCT to hard-to-reach populations and coordinate closely with champion communities to ensure that HCT is available in targeted areas. HCT will also be provided in health facilities as part of the integrated service package offered and in line with the national strategy for promoting provider-initiated counseling and testing (PICT) and in stand-alone HCT centers managed by ProVIC partners. Based on lessons learned in Year 1, ProVIC will strategically target HCT services for populations in greatest need through all of these types of facilities and by deliberate outreach to MARPs. This will be done in close coordination with the community mobilization component so that we capitalize on community networks and resources. The project will also prioritize integration of family planning with HCT as well as the reference and counter reference for TB services, and make sure these practices are standardized across facilities through capacity building for providers.

Activity 1: Continue providing support to existing HCT centers and partners

Structures providing HCT services in 2010 will continue to receive support in the second year of the program to carry out outreach and testing activities. An action plan with defined strategies will be developed for each structure in order to reach out to MARPS with mobile HCT services or to provide them with referrals to the nearby service delivery points.

In addition, PROVIC will promote PICT (Provider Initiated Counseling and Testing) by involving nurses, medical doctors, and other providers at the facilities where we work so that every time they see a patient, the patient is given the opportunity to receive an HIV test. The pre-test, test and post test will be performed during the period the patient or client is being

seen by the service provider. If well done the PICT has the potential to boost the level of confidence, confidentiality and trust between patient and service providers.

In collaboration with the M&E team, monthly supportive supervision visits will be organized by the Regional Prevention Specialist at each structure to assess the level of performance and the quality of services being provided. Every quarter there will be joint supervision by the national HCT Specialist and the Regional Prevention Expert to provide assistance and support to service providers. HCT sites by province are outlined in Table 2 below.

Table 2: ProVIC HCT sites, by province

| Province | City/health zone | Organization/partner | Type of service |
|------------------|-----------------------|-------------------------------|--------------------------------|
| Kinshasa | Matete | FFP | Community-based HCT |
| | | FFP | Mobile HCT |
| | Kasa Vubu | AMO-Congo | Community-based HCT |
| | | AMO-Congo | Mobile HCT |
| | Masina I& II | PSSP | Community-based HCT |
| | | PSSP | Mobile HCT |
| | Masina I | HBMM | Facility-based integrated HCT |
| Bas Congo | Matadi | AMO-Congo 1 | Community-based HCT |
| | Nzanza | AMO-Congo 2 | Community-based HCT |
| | Matadi, Nzanza | AMO-Congo 3 | Mobile HCT |
| | Matadi, Nzanza | HGR Kiamvu | Facility-based integrated HCT |
| | Matadi, Matadi | CSR Mvunzi | Facility-based integrated HCT |
| | Matadi | Jadisida | Mobile and community-based HCT |
| | Kinzamvuete | Fosi | Community-based HCT |
| Katanga | Lubumbashi | World Production | Mobile HCT |
| | Lubumbashi, Rwashi | AMO-Congo 1 (CDV Jeune) | Community-based HCT |
| | Kampemba | AMO-Congo 2 | Community-based HCT |
| | Lubumbashi | AMO-Congo 3 | CD Mobile |
| | Likasi/Kikula | World Production | Community-based HCT |
| | Kipushi/Kipushi | World Production | Community-based HCT |
| | Kasumbalesa /Sakania | AMO-Congo 4 | Community-based HCT |
| | Lubumbashi, Kenya | HGR Kenya | Facility-based integrated HCT |
| | Likasi/Panda | HGR Panda | Facility-based integrated HCT |
| | HGR Kampemba | Facility-based integrated HCT | |
| Sud Kivu | Bukavu/ Ibanda | FFP | Community-based HCT |
| | Bukavu/Ibanda, Bagira | FFP | Mobile HCT |
| | Nyantende | HGR Nyantende | Facility-based integrated HCT |
| | Bagira | HGR Bagira | Facility-based integrated HCT |
| | Uvira | SWAA | Mobile and community HCT |

Activity 2: Train HCT service providers in the integration of family planning and gender

Integration of FP services and gender into HCT provides numerous advantages to both HIV positive and negative clients/patients. Both men and women of different ages will be given equal access to services. In the case of a woman client that tests HIV+, family planning services will be presented as the best option to prevent unwanted pregnancies which could trigger mother-to-child transmission of HIV. In addition, integration of FP into HCT services will reduce the stigma associated with any visits to a HCT center. This information will be shared with different categories of the population including men and women, MARPS, etc.

The current situation is that there are two different advisors in some HCT centers, one dealing with HIV/AIDS and the other dealing with FP related services. Many clients get lost throughout this process of referral and counter referral between the two services. As a strategy to deal with this situation, HCT advisors will be trained in FP service delivery in collaboration with both PNLs and PNSR. Prior to this training a common data collection and reporting tool will be developed and adopted for use by all parties concerned.

Activity 3: Support the opening and functioning of new HCT centers in champion community sites

Once the process of selection and delimitation of champion community sites is complete, the HCT specialist will arrange to link each champion community to a mobile, community, or facility based HCT service site. Where possible, we will consider integrating these services into existing health centers, which can continue the delivery of the same services at the end of funding from ProVIC. Some support will be provided for the rehabilitation and equipment of HCT centers as needed and in coordination with the contributions of the center itself.

The capacity of all new HCT centers will be strengthened and their service providers trained as mentioned above. National norms related to HCT centers will be disseminated to ensure the quality of services provided. Providers from previous HCT supported by the program will also participate in the training to refresh their technical knowledge and skills. PNLs will be actively involved in the design and implementation of this activity.

We assume there will be a significant increase in the number of persons being tested as the capacity of structures and providers is strengthened and the PICT that encourages other clients to seek HIV testing.

Activity 4: Ensure the procurement of HCT related commodities and other pharmaceutical and laboratory products and supplies

A procurement plan for HCT related commodities and supplies will be developed to ensure smooth functioning of HCT centers. The plan will provide details on the processes related to the quantification of needs and quantities, the selection of suppliers, the bidding requirements, frequency of delivery, time between the placement of order and delivery. It is understood that stock outs will be significantly reduced with the addition of a well articulated procurement plan.

In depth analysis of the current storage and distribution system will be done to explore how ProVIC's plan can be integrated into national procurement which has branches in provinces covered by the program. The collaboration with MSH/SPS will be consolidated and fully used to ensure effective management and utilization of commodities and supplies, and in joint training activities related to commodities.

Activity 5: Establish linkages between HIV-TB co-infection by ensuring that PLHWA are tested for TB

ProVIC will work with the Programme National de Tuberculose (PNT) to harmonize strategies on how to orient HIV + clients to TB testing centers at both the national and provincial levels. We will work with them in preparing a detailed map of the diagnostic and treatment centers for TB (CSDT) and the simple diagnostic centers (CDT) in our intervention areas, and then we will establish a referral and counter referral system so that our sites working with HIV+ clients know where to refer patients for TB testing and TB testing and treatment sites have information on where to refer TB patients for HCT. This will be done in coordination with the new USAID-funded PATH-led TB project starting in November 2010. For sites that provide both TB and HIV testing services within their facility, we will provide ongoing capacity building and help them reach out to those in the community with tuberculosis to also receive HIV testing. Finally, as part of our training for HCT service providers, we will organize sessions on HIV-TB co-infection, the risks, appropriate referral procedures and other relevant information.

Activity 6: Produce and disseminate HCT and relevant M&E tools

To ensure and improve management of data in HCT sites, a data base for both VCT and PICT will be developed to capture necessary program information. The data base can be used to track the performance of each participating center or structure and can be a resource for analyzing results for trends, lessons, and areas for improvement. Complementary to this, each site will be provided with the required tools for data collection such as registers, lab forms, and other patient records. To accomplish this, the project will first survey all existing tools to determine what is still needed and develop anything additional to cover identified gaps. Then, we will ensure all HCT sites have these tools available to them in the quantities they need.

Activity 7: Organize the referral and counter referral system

As an integrated HIV/AIDS program, we will work with government and other partners to create an inventory of existing tools, documents, guidelines related to HIV related referrals and counter referral systems and practices. This exercise will help to identify gaps, relevance and strengths and to propose a common system which can be used by all parties involved in HIV services and activities. Once established the new system will be implemented in all provinces covered by ProVIC in collaboration with the Coordinating Teams of the concerned Health Zones where champion communities are being implemented. Exchange meetings will be organized with other partners to create synergies and detect or address any obstacles preventing the utilization of the new system.

Activity 8: Assure the quality of HCT services in the centers and communities

The quality of services provided will be assured through both internal and external quality controls. ProVIC will put in place a system of quality control for each of our HCT partners. This will include aspects of what tests are used, how they are used by advisors and service providers, the recording of results data, the management and utilization of commodities and supplies, and the management of HCT related bio medical waste. External controls will include regular submission of samples to provincial and national reference laboratories for the validation and confirmation of the results. These quality control systems will be documented by the project and service providers will receive training in their implementation. In addition, regular supervision and evaluation will determine to what extent procedures are being followed and what improvements are needed.

Activity 9: Reinforce the capacity of HCT centers in the management of biomedical waste

This activity will be carried out in collaboration with implementing partners and participating hospitals and health centers receiving ProVIC financial and technical support. A package of essential activities will be developed and included in the work plan of each ProVIC implementing partners involved in HCT services. The management of bio and medical waste from the point of production, manipulation, storage, conservation, transportation to disposal will be stressed for each HCT partner. The capacity of structures and service providers will be reinforced through integrated training; the community will be mobilized and educated to deal with bio medical waste. In order to ensure that biomedical waste are effectively managed in compliance with national guidelines and USAID norms and regulations, ProVIC will intensify regular follow up to sites, provide necessary material, equipment and supplies, rehabilitate or construct incinerators, and work with provincial and hospital and health center teams to ensure the compliance.

Activity 10: Coordinate activities with other partners

To leverage resources and increase impact, PROVIC will work with many partners under the HCT component. Many of these are documented in the partnerships section above. In the HCT component, we will work particularly with PSI in planning prevention campaigns and in taking advantage of materials they may have that can be used in project HCT sites. We will also continue to build on our critical partnerships with government by supporting PNLs in making joint supervision visits and in their preparation of PICT tools. Lastly, we plan to work closely with PNLs on improving couples counseling in HCT sites.

Year 2 milestones

- Funding for existing services continued.
- Evidence-based recommendations made to improve HCT services.
- New HCT sites selected.
- Family planning and gender activities integrated into HCT services.
- Capacity of CSDTs improved in providing or referring patients to HCT.
- Biomedical waste management plan put in place in all ProVIC centers and enforcement mechanism activated with the provincial governments.

Sub-IR 1.3: PMTCT services improved

Overview and strategy

In Year 2, PMTCT services and activities will be implemented using a comprehensive approach, taking into account the four prongs of PMTCT (1. Primary prevention of HIV infection among women of reproductive age; 2. Prevention of unintended pregnancies among HIV-positive women; 3. Prevention of transmission from HIV-positive women to their infants; 4. Provision of care, treatment, and support services for mothers, their children, and families) in order to effectively contribute to the elimination of pediatric HIV/AIDS. This comprehensive approach will target both HIV-positive and HIV-negative pregnant women providing high-quality PMTCT services and education for HIV-infected women as well as tools and education for HIV negative women to preserve their negative status. ProVIC will continue to build the capacity of PNLs at the national level to ensure effective implementation of the new national guidelines for PMTCT and pediatric care. In year 2 the project will use the champion community approach to mobilize pregnant women and facilitate their access to PMTCT services: For example, increase community awareness about the importance of early ANC uptake and male partner involvement, encouraging delivery in

PMTCT sites and retention in the PMTCT program. The PMTCT team will focus on maintaining a continuum of care by introducing tools and tracking systems to reduce loss to follow-up for both women and infants throughout the cascade of PMTCT services and ensure effective linkages to care, treatment, and MCH services.

Activity 1: Strengthen the capacity of government at the national level to provide PMTCT services

In Q1, an international expert will assess the state of PMTCT in the DRC and provide recommendations to address two high-priority gaps in the continuum of HIV/AIDS care identified during the Y1 needs assessment:

1. The identification of HIV-exposed infants and children.
2. Linking exposed infants and their families from PMTCT services into care and treatment.

The international expert's recommendations will further inform and refine activities at both the national and provincial levels and national level TA provided in Y2. Dr. Ditekemena will continue to provide technical assistance to PNLs to revise PMTCT and pediatric care training materials according to the new World Health Organization (WHO) guidelines. In Qs 3 and 4 The PMTCT, M&E and Pediatric Specialists will assist PNLs and PNMLS in revising PMTCT and pediatric care data collection tools and the national M&E plan to reflect these changes.

Activity 2: Increase promotion and uptake of pediatric counseling and testing and improve follow-up of mothers and infants

In Q1, Drs. Ditekemena and Katabuka will begin to develop tracking systems for mother-baby pairs who miss follow-up visits after accessing PMTCT services. Beginning in Q2, Dr. Ditekemena will establish a simple system for clinical follow-up of HIV-positive women and their infants throughout the cascade of PMTCT activities. Throughout the year, Dr. Katabuka will reinforce and troubleshoot the early infant diagnosis (EID) system developed in Year 1, ensuring smooth collection and shipment of samples to Kinshasa or Lubumbashi for testing and efficient return of results to both clinic staff and families. Building on the mapping exercise conducted in Year 1, he will support the referral of infected infants by increasing the proportion of infected infants on treatment and number of exposed infants receiving cotrimoxazole prophylaxis. In Q2, Dr. Katabuka will implement strategies to identify and track HIV-positive women and their infants through various maternal and child health services to reduce missed visits and improve infants' retention in care. During routine site visits, he will conduct a clinical quality assessment to monitor the quality of pediatric care provided.

Activity 3: Provide technical assistance and capacity-building in PMTCT to new MSH project sites in geographic areas targeted by ProVIC

During Year 2, ProVIC plans to support MSH's new follow-on project to Project AXxes, that is scheduled to end in early 2011. ProVIC's PMTCT team will continue to support the provision of high-quality PMTCT services at the regional level, and at ProVIC-supported MSH project sites (previously AXxes sites) in Katanga and Sud Kivu, in consultation with USAID, MSH, and new project partners. A memorandum of understanding will be signed to define these relations.

ProVIC will provide capacity-building assistance based on the results of program assessments conducted in Year 1, building on the technical assistance provided by Dr. Ditekemena to the AXxes project at the regional and site levels. Technical assistance will focus on five major identified gaps: inefficient client flow, lack of confidentiality; low male-partner involvement; weak linkages with other MCH services; gaps in the continuum of care, and low levels of mentoring for clinic staff. Drs. Ditekemena and Katabuka will ensure the effective implementation of this plan through support, supervision, and mentoring. Support will include site visits, bi-weekly meetings with national-level staff from the new MSH project, and follow-up conference calls with provincial supervisors.

To continue to reinforce the capacity of new MSH project service providers in their respective health facilities, Drs. Ditekemena and Katabuka will conduct a follow-on training for supervisors and selected health zone staff on mentorship, the new PMTCT guidelines, PICT, and PMTCT-specific supportive supervision techniques. They will also use the training to address service gaps identified during site visits.

Activity 4: Increase the quality of PMTCT services provided

In Q1 and Q2, Drs. Ditekemena, Katabuka and the ProVIC Provincial Prevention Specialists will organize on-site trainings on the new PMTCT and pediatric care guidelines for all providers involved in PMTCT activities and services to ensure that skills are up-to-date and providers are comfortable working with the new drug regimens (pending procurement of appropriate commodities). These trainings will include doctors, nurses, lab technicians, and counselors at ProVIC-supported sites.

The ProVIC PMTCT team and trainers of trainers trained in Year 1 will reinforce these in-service trainings with on-site mentoring and supervision. To address the challenge of staff turnover, ProVIC will establish a system of in-service trainings, to be conducted by the pool of trained trainers, and provincial prevention specialists to help strength the capacity of new staff and ensure service continuity.

Drs. Ditekemena and Katabuka have been tasked with supporting project efforts to reinforce the linkages between PMTCT activities and family planning services. Pending availability of appropriate commodities, Dr. Ditekemena, Dr. Katabuka, and the provincial prevention specialists will ensure that all HIV-positive pregnant women and their infants receive antiretroviral (ARV) prophylaxis and treatment in accordance with the new National Guidelines on PMTCT and pediatric care. They will also work with clinic staff to strengthen primary prevention counseling for HIV-negative women during the traditional three-day postpartum stay at maternity wards. During Q3, Dr. Ditekemena will supervise an international expert who will help develop a plan to implement quality improvement (QI) strategies at ProVIC PMTCT sites, adapting them to the DRC context. Following training of prevention specialists on QI tools and approaches during Q3, these tools and approaches will then be rolled out to all ProVIC PMTCT sites in Q4.

Recognizing the importance of ensuring appropriate biomedical waste management in PMTCT centers, ProVIC will institute a biomedical waste management plan in all PMTCT sites and recommend an enforcement mechanism in cooperation with provincial governments.

Activity 5: Improve access to comprehensive PMTCT services

Beginning in Q2, Dr. Ditekemena and Community Mobilization Specialist Dr. Mulongo will work together to integrate PMTCT targets into the Champion Community model, leading to increased uptake of PMTCT services and male involvement. To increase male involvement in PMTCT activities, community volunteers will coordinate discussions on male norms and culture with a view to changing men's attitudes and behavior toward involvement in PMTCT activities, including family planning. The ProVIC PMTCT team will also help strengthen provider capacity and enhance the quality of venues where services are provided to make them more welcoming to male partners.

Recommendations from the international gender consultant, Monique Widyono, following her July 2010 gender assessment will be used to implement a gender-sensitive approach and improve PMTCT service providers' capacity to identify cases related to gender-based violence (GBV), provide appropriate care and support, and refer them, if needed, to specialized care and treatment centers. To this end, each PMTCT site, as with other ProVIC sites, will be provided with an information package on GBV and available care, support, and treatment sites.

Dr. Ditekemena and Katabuka will also liaise with the ProVIC care and support team to ensure that the male partners of HIV positive pregnant women are referred to the most accessible HIV care facilities. Findings from the KSPH/UNC operational research (OR) study on the uptake of PMTCT interventions by HIV-positive women will be incorporated into ProVIC's PMTCT strategy as soon as these findings are published.

In Q3, the project's PMTCT and pediatric specialists will conduct follow-up site visits to ensure the effective integration of gender approaches and family planning with PMTCT services. In Q4, provider-initiated counseling and testing (PICT) will be rolled out to all 24 ProVIC PMTCT sites with a view to increase the uptake of PMTCT services.

Year 2 milestones

- PMTCT assessment and continuum of care report produced and disseminated.
- Training materials and M&E tools revised at the national level.
- Agreement on the role of ProVIC support to MSH project sites negotiated with USAID and MSH.
- PMTCT activities integrated into Champion Community model.
- Staff trained and QI tools implemented at all ProVIC PMTCT sites.
- Tracking systems for mother-baby pairs rolled out to all sites.
- Gender and family planning activities integrated into PMTCT services.
- Effective and appropriate mechanisms in place to handle hazardous biomedical waste.

Table 2. Year 2 targets (Sub-IR 1.3)

| N° | Indicators | Number/Percent (%) |
|----|---|--------------------|
| 1 | Number of health facilities providing antenatal care services that include both HIV testing and antiretrovirals for PMTCT on site | 24 |
| 2 | Number of pregnant women who were tested for HIV and know their results | 23000 |
| 3 | Number of HIV-positive pregnant women who received ART to reduce risk of mother-to-child transmission | 460 |
| 4 | Percentage of infants born to HIV-positive women who received an HIV test within 12 months of birth | 20 |
| 5 | Percentage of infants born to HIV-positive women who were started on cotrimoxazole prophylaxis within two months of birth | 20 |

Intermediate Result 2: Care, support and treatment for PLWHA and OVC improved in target areas

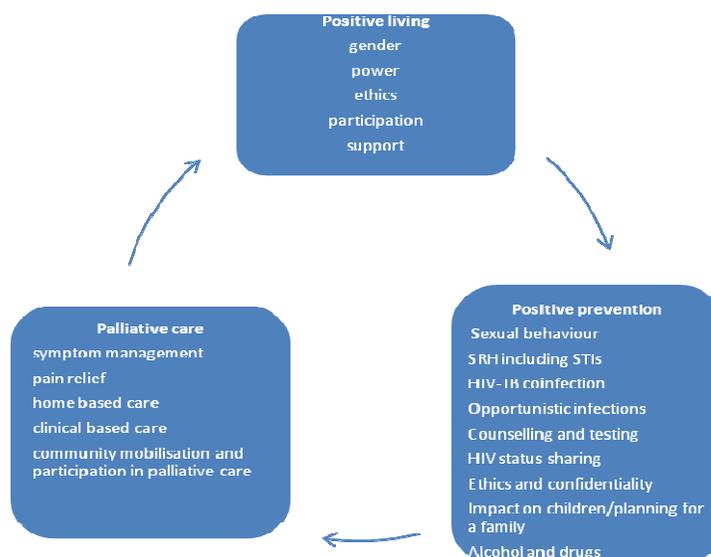
Overview and strategy

The project will target PLWHA, OVCs, and their communities in this component and will involve them in every step of implementation. Activities will be centered on the community, and we will adopt the USG’s strategy of integrating palliative care into the framework of the Family-Centered Continuum of HIV services.

For people living with HIV/AIDS, we will improve both the clinical aspects of palliative care and provide a holistic package of care and support interventions that enhance their health, social and economic status. This includes interventions such as:

- The positive living strategy (see Figure 3 below).
- The positive prevention strategy.
- The palliative care strategy.
- The child to child approach.

Figure 3: Overview of positive living strategy

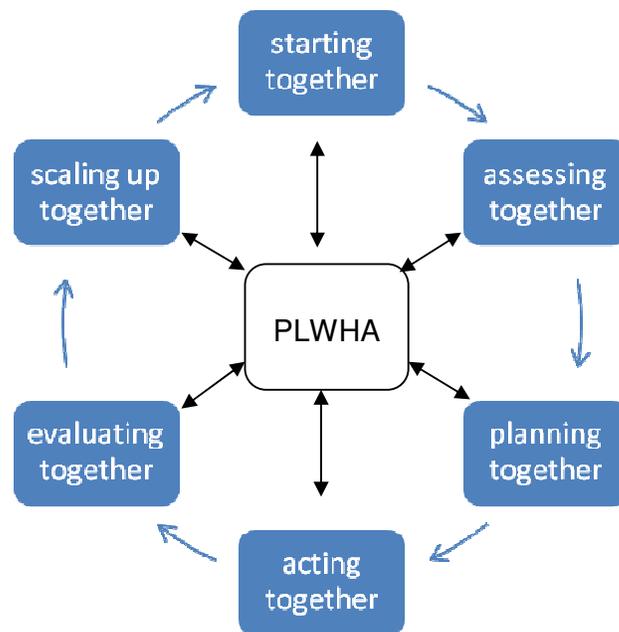


The positive living strategy

The concept of ‘positive living’ is based on a vision: That of a world where people do not die or suffer unnecessarily from AIDS. However, to reach this vision necessary conditions need to be created where people living with HIV/AIDS (PLWHA) can live productive and dignified lives for as long as possible, in good health and with a focus on living positively.

Enabling PLWHA to live positively means, improving their quality of life by helping them to respond, themselves, with the support of others, to the multiple challenges they face. Community engagement and mobilization will be a key strategy in supporting PLWHA to identify and address the range of complex issues that they encounter. The key phases of the model are mapped in Figure 4 below.

Figure 4: Key phases of positive living model



Applying this model to community mobilization for positive living provides a support framework for PLWHA. This is in contrast with the approach, which focuses only on the delivery of bundled activities within the care and support context. The community mobilization approach, described above, helps to foster, amongst the community of PLWHA, a spirit of entrepreneurship, participation and a sense of engagement with their own health and that of their families.

There is also an aspect of the model that addresses human rights, dignity and self-reliance. With positive living at its centre, community mobilization becomes the framework for self-expression, reflection and action, which, in turn, works to further propel change on an individual and collective level.

Strengthening the capacity of, and improving and increasing the opportunities for PLWHA to discuss the challenges they face, without restriction, create the conditions where people can work together to share experiences, explore different solutions and potential areas of cooperation and collaboration, both within and outside their communities. This approach

encourages groups of PLWHA to move progressively towards weaving strategic partnerships with community networks, human rights groups, religious leaders and others.

Because this mobilization will be family focused, it will link work with PLWHA with work with OVC. It will be a comprehensive and coordinated care approach that addresses the needs of both adults and children in a family. It will meet the health and social care needs of OVC, either directly or indirectly through strategic partnerships and/or referrals to other service providers.

The impacts of HIV both social and economic are experienced by families as a whole, not only by the individual who is HIV positive. For example, stigma and discrimination may affect the family as a whole; if one family member is unwell other family members may need to take on additional work to maintain the family's income; costs of treatment, transport or funeral costs can deplete the available financial resources of the family.

There are three clear aspects of the family-centered approach:

1. The needs of the whole family rather than the needs of particular individuals within the family are addressed.
2. Both social care and health needs are addressed.
3. Needs are met by a number of different groups and referrals which require strong coordination mechanisms.

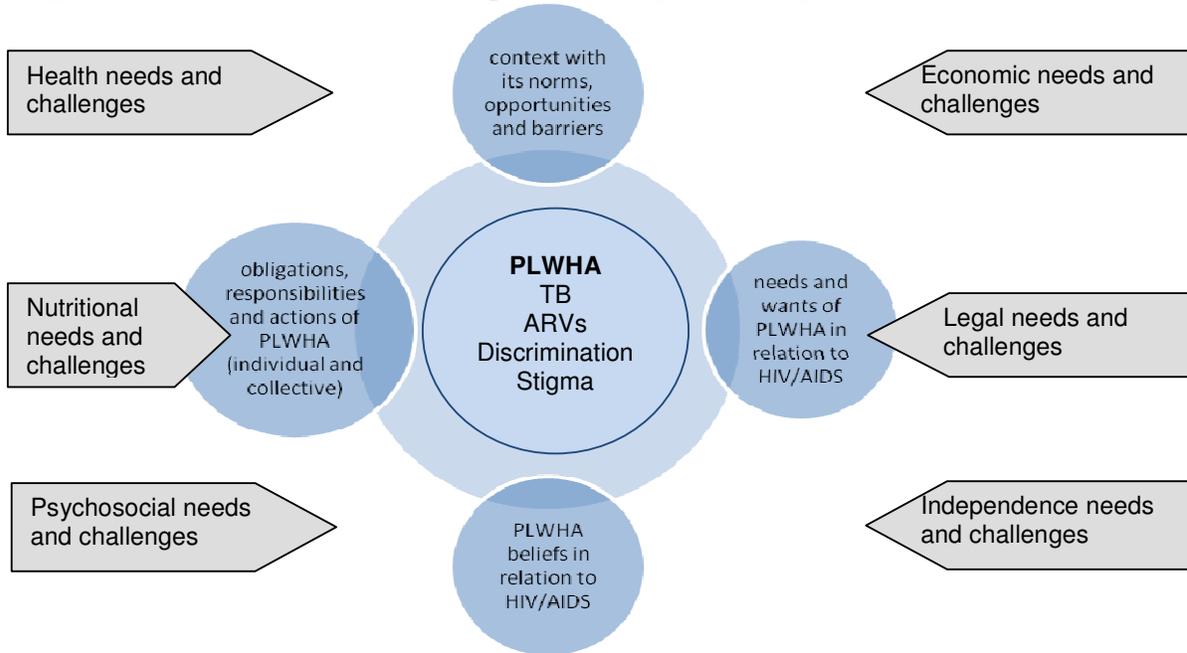
It is important to link care and support work for OVCs with care and support work with the families in which they are situated. It is in families that decisions are made concerning children's welfare, care and support and concerns about child care can often be an additional source of distress for PLWHA. Thus, for example, health and education seeking decisions are made within families and support in decisions concerning current and future child care arrangements made by sick or dying parents can be an important aspect of their palliative care as well as crucial for the future wellbeing of orphans.

Even within traditionally non-family settings such as orphanages and institutions, a family centered approach takes into account the wider support environment. Child protection is a vital element of this approach and all activities should have the safety, care and protection of children at the centre.

Community mobilization implementation mechanism

Groups of PLWHA will be supported and consolidated to function as 'self-help groups' with a focus on working within the wider community in order to address challenges and take advantage of opportunities that exist within the community. Figure 5 below illustrates, on a macro level, the challenges and the framework within which PLWHA will address them and share successful strategies.

Figure 5: Community mobilization implementation framework for PLWHA



Within the self-help groups, the identified needs can be ranked and structured following the logic and priority of the group’s participants. Often, practical and affordable solutions can be found through this process. However, referral and counter-referral to other services and access to additional information from outside sources can also be appropriate where the identified challenges exceed the possibilities and capacities of the group. Referral in this sense can also include creating relationships of cooperation and collaboration with the wider community in order to resolve issues.

In addition, PLWHA will be assisted in conducting a community audit to identify the availability of quality resources and opportunities to respond effectively to their identified needs and wants.

The positive prevention strategy

Positive prevention is a methodology that centers on PLWHA and emphasizes informed and deliberate choices made by a PLWHA to live positively. Positive prevention is a strategy designed to reduce the risk of secondary infection amongst PLWHA, as well as to reduce the risk of infecting others.

This approach allows PLWHA to take control of the process of improving their quality of life and optimizing their well being. The aim is to promote strategies and approaches that reduce risk and also promote a way of living that is based on making responsible choices.

Discussions on positive prevention will be supervised by the Care and Support and Home-based Care specialists.

The palliative care strategy

In order to facilitate the access of PLWHA to quality palliative care that is based on good practices, ProVIC will involve both national and provincial government partners or

stakeholders, NGO partners, networks of PLWHA and Care and Support staff, to define and develop an appropriate methodology for providing palliative care and services to PLWHA. The multidisciplinary team will work together to ensure the continuum of care and support between the individual, the family and existing health structures.

The image associated with 'palliative care' is often one of bedridden patients, suffering great pain requiring constant care. Although palliative care has a clear role to play in such contexts, it also covers good practice in areas such as hygiene, good nutrition, and dealing with gradual as well as sudden increases of pain and other symptoms and the provision of psychological, social and spiritual support .

The goal of palliative care is ensuring of the best quality of life for patients, their families and communities. Palliative care activities take place within the formal health care systems, but can also take place within a home setting with the involvement of family and with support from nursing staff.

The links between positive prevention and palliative care are clear: Where palliative care services and support are underdeveloped in terms of outreach and scope, prevention of HIV becomes a key strategy in reducing the impact of the epidemic and reducing the burden on a weak palliative care system. However, palliative care still has a major role to play in positive living strategies for PLWHA.

The child to child approach

A second strategy for addressing the care and support needs of OVC will be based upon a child to child methodology. This is an approach, rooted in health communication, which encourages children to play an active and central role in their own development. It is based on the belief that children can be actively involved in their communities and in solving community problems. Child to child projects involve children in activities that interest, challenge and empower them with the aim of achieving positive change on three levels: (i) Communal impact on families, children, local professionals and others, including increased knowledge and positive changes in health attitudes and behaviors, as well as improved relations between adults and children or institutions and children; (ii) Personal impact on children involved including increased knowledge and skills, improved self-confidence, and the development and strengthening of friendships and other relationships; and (iii) Increased respect for children's ideas and abilities

The child to child approach applied alongside the Positive Living mobilization for PLWHA and with the Champion Communities and elsewhere, will allow OVCs to identify, analyze and understand their own needs and wants. Through working with peers and supported by implementing NGOs, they will be able to build their confidence, explore their fears and hopes and work together to find solutions to their problems. To further enable them to do this effectively there will be a key focus on the range of life skills for children (up to 13 years), adolescents (14-19 years) and young adults (20-24 years). It is expected that this approach will encourage and support discussions on key issues such as gender based violence, economic strengthening, health and nutrition, and psychosocial and educational support.

Sub-intermediate results

Sub-IR 2.1: Palliative care and support for PLWHA strengthened

Sub-IR 2.2: Care and support for OVCs strengthened

Sub-IR 2.1: Palliative care and Support for PLWHA strengthened

Activity 1: Reinforce the capacity of PLWHA on positive living, positive prevention and palliative care

The Care and Support Specialist (Alioune Badara Sow) will work with the HSS Specialist, Elyse Zambite, and Community Mobilization Specialist, Salva Mulongo, to train four representatives from each of the four ProVIC provinces: One from PNMLS, 1 from local NGO, 1 from network of PLWHA and 1 regional care and support specialist. The training will be focused on positive living, positive prevention and palliative care for PLWHA.

It is understood that once capacitated, these trainees, will be able to facilitate self help groups' meetings and events on positive living, positive prevention and palliative care. This five-day workshop will be held in Kinshasa with the participation of trainees from the provinces. The ProVIC Home-Based Care specialist, soon to be recruited, will be fully involved in this workshop.

This workshop will be designed based on terms of reference developed to ensure that the main areas of positive living, positive prevention and palliative care are covered. It is scheduled to take place in November 2010. This ToT workshop in Kinshasa will be followed by ToP (Training of Partners) at the provincial level.

Activity 2: Develop and apply a methodology for good practice audits of care and support arrangements available to communities

ProVIC will develop a methodology for conducting audits within defined areas on care and support services available to PLWHA. This will look at all aspects of the care and support spectrum and assess quality, access issues and service gaps in comparison with recognized and evidence-based good practice. The methodology will be developed and field tested by a ProVIC and NGO partner team under expert guidance. The team will then apply the methodology in all implementation areas. The results will inform care and support plans and delivery.

Activity 3: Organize self-support groups on positive living, positive prevention and palliative care

In Year 2, 378 self support groups will be constituted and capacitated on positive living, positive prevention and palliative care by implementing NGO's in the four provinces. The discussions around these themes will be strongly linked with the indicators and followed by concrete actions such as referral of PLWHA to CSDT for TB testing. The 4 regional care and support specialists will be involved in these activities to ensure technical quality of discussions and encourage PLWHA to fully participate in the discussions and, subsequently, to take positive actions in their daily lives.

Activity 4: Organize home visits to provide psychosocial, nutritional, spiritual, palliative care and support to PLWHA families, including ensuring the effective management of any bio-medical waste

Each implementing partner will conduct home visits to PLWHA families via volunteers. These home visits will be supervised by Home Based Care and Regional Care and Support Specialists. These visits will present opportunities to meet with PLWHA who missed appointments to receive care and support treatments. They will also be opportunities to monitor adherence to treatment and discuss with family members issues surrounding

psychosocial, nutritional, spiritual, palliative care, and the management of biomedical waste. The decision, on which family will benefit from home-based care, will be made in collaboration with implementing NGO's, community volunteers and the networks of PLWHA.

Activity 5: Ensure promotion of the law protecting PLWHA

The law protecting PLWHA is not sufficiently known or understood by the stakeholders whom it is meant to protect. This law should become a key framework around which PLWHA can contextualize the responses and plan actions to the challenges they face. In order to ensure that PLWHA have access to information on this law, the Care and Support Specialist will disseminate the appropriate legal information to the self-help groups via the implementing NGOs and PLWHA networks, and also distribute copies of the law translated into local languages where possible and necessary, to facilitate focused discussions on the issues.

In addition, community forums will be organized during the World HIV/AIDS Day at the provincial level to raise awareness around the law and ensure its proper dissemination. The provincial government has a key role to play in supporting and facilitating the dissemination of this legal information. However, implementing NGOs also have a role in making this information accessible to a wider audience within their particular contexts. Furthermore, ProVIC will provide assistance to PLWHA confronted with specific legal issues by referring their cases to the appropriate legal support structures, including, for example, NGOs with a human rights focus. The audit of services and resources covering this will also be captured by the implementing NGO's.

Activity 6: Ensure income-generating activities for PLWHA

Each of the implementing partners will initiate income generating activities for PLWHA and their families. ProVIC will engage an income generating activity consultant who will work with the champion community model to design of income generating activities and link the beneficiaries with the market. The manner in which the benefits from these IGA's will be reinvested to support care and support for PLWHA will be defined by each Champion Community.

Activity 7: Organize a cross fertilizing day on positive living, positive prevention and palliative care

Sharing lessons learned is a crucial opportunity to insure mutual and horizontal learning among implementers, target groups and the health service providers. In collaboration with the Community Mobilization Specialist, a cross-fertilizing day will be held in each province during Q3. Best practices will be shared and documented in order to be used for replication and scaling up. This activity will be facilitated by a moderator with strong communication and facilitation skills.

Milestones

- 5 workshops on positive living, positive prevention, and palliative care organized in Kinshasa, Sud Kivu, Katanga and Bas Congo.
- 100 persons capacitated to transfer knowledge and build skills in positive living, positive living and palliative care.

- 378 self support groups organized by implementing partners.
- 7925 PLWHA reached by self support groups and referred to health centers or appropriate health services for specific needs (family planning, STI's diagnostic, opportunistic infections, etc), have participated in discussions around the law protecting PLWHA and received a copy each of the law.
- A community forum held in each province during the World AIDS day to reach at least 500 people and 2000 copies of the law are distributed during these fora.
- An audit of services and resources is done to create 'alert systems' and mechanisms for those PLWHA who might need referral to legal assistance.
- 95 % of PLWHA put on cotrimoxazole.
- 100 persons trained on positive living PLWHA.

Sub-IR 2.2: Care and support to orphans and vulnerable children (OVCs)

Overview and strategy

In the ProVIC context, OVC includes children under 18 living with HIV/ AIDS, or with one or both parents dead from or living with HIV/AIDS, or children who are exposed to conditions under which if appropriate actions are not taken risk being infected by HIV.

Our approach in providing care and support to OVC is based upon the findings of USAID's 2009 Rapid Assessment, Analysis and Action Planning (RAAP) on OVC programming in the DRC, and on PEPFAR guiding principles.

The findings recommend putting strong emphasis on the following aspects:

- Food and nutrition
- Shelter and care
- Protection
- Health care for OVCs and HIV+ children
- Psychosocial support
- Education
- Vocational training
- Economic opportunities/strengthening

ProVIC will develop innovative approaches for OVC that aim to focus on these crucial aspects through two linked strategies. Thus, "family centered" and "child to child" approaches will be deployed within the context of communities and based upon PEPFAR guidance and standards for OVC programming. At the same time, we see Year 2 as a *transitional year* during which, we will seek to maintain but phase out the targeted welfare approaches that have been deployed widely to address OVC's problems, while developing and introducing more sustainable approaches.

Activity 1: Ensure that the process of mobilizing PLWHA (described under Sub-IR 3.1), engages them to support and ensure the welfare and wellbeing of their children

During the training workshop on positive living, positive prevention and palliative care, participants will be oriented and capacitated, to plan for community level activities that address children and child care needs during PLWHA self-help group discussions on positive living. Orientation will also be given in the use of child to child approach. This workshop is described more under the section 3.1.

Activity 2: Reinforce the capacity of grantees, champion communities, teachers, and tutors to work with OVC through “child to child” methodology

This is a joint seven day national workshop to be organized in the first quarter in Kinshasa to train 20 adults from government (MINAS, PNMLS), PLWHA groups, representatives of grantees, Champion Communities, teachers and tutors on child to child approach. The training will be done in terms of TOT to sharpen skills of trainees in methodology related to adult learning, knowledge acquisition and transfer. Each trainee will in turn organize training activities for OVC in her/his respective province or community. The Care and Support Specialist will work with the HSS Specialist to develop training materials and ensure the logistics of the activity. See activity 1 under the PLWHA section.

The implementation will be organized using the following steps:

- Introduction to child to child approach (overview on historic, philosophy, methodology, and principles).
- How to understand OVCs needs using participatory methodology and linking them with PLWHA Work Plan, and community mobilization.
- Specific discussions on themes affecting OVCs (health and nutrition, education, OVC placed in host shelter, economic strengthening, psychosocial support, social inclusion, negotiation of difficult situations with adults, adults rapes, violence and child protection, child well being, etc.).
- Skills to moderate child to child discussions.
- Develop targeting criteria for interventions.
- Practical experience with focus groups of OVCs in the community.
- How to organize child to child groups.
- How to develop a child to child TOP training plan.
- How to organize OVCs referral.
- Supportive supervision.

Activity 3: Organize groups discussion with OVC peer educators on child to child approach

The Care and Support Specialists will train selected OVC in each region in the approach learned during the Kinshasa workshop so that they can in turn facilitate child to child groups. ProVIC’s implementing partners will then organize 280 sessions using the approach in all program sites. The sessions will be led by the trained OVCs.

During sessions on child to child, there will be an adult assuming the role of a facilitator just to ensure that discussions are conducted in a proper manner. The sessions will be organized in each champion community and the issues and recommendations raised by OVC will be taken into account by grantees providing services to OVC in that community. Peer discussions will integrate life skills to negotiate difficult situations, needs of OVC related to nutrition, schooling, primary health, child protection against adults rapes and violence, psychosocial support for OVC placed in host family, child well being, etc

Activity 4: Provide educational and vocational support to OVC

In Year 2, ProVIC will continue to support OVC access to school by contributing to paying school fees and kits while also working with children (through child to child), families (through the positive living mobilization), communities (through champion communities) and

schools, to find more sustainable solutions. This focus will look at both access and quality of education.

ProVIC intends to provide educational and vocational support to 3170 OVC. School fees and kits will be distributed on the basis of pre-arranged targeting criteria. At the same time grantees will engage with schools to ensure that OVCs achieve good academic performance. During the year work will be done to ensure that an alternative and more sustainable approach to promoting schooling for OVC will be developed before Year 3.

As Champion Communities are established, ProVIC will work with them and schools to ensure more sustainable and effective ways of ensuring that OVC get the schooling they need. For example, arrangements will be made with selected schools to provide them with a one-time investment (materials, equipments, rehabilitation) which will allow OVCs enrolled in the program to access schools for an agreed upon period of time, for free.

In addition, 25 OVC per champion community will be supported for vocational training based on their choice. In the meantime, ProVIC will coordinate with other partners such as Global Fund, UNICEF, FAO, World Vision, the World Bank and others to leverage available resources.

Activity 5: Provide nutritional support to malnourished OVCs

There is currently a lack of knowledge concerning the nutritional status of OVCs in the program areas. As a result it is difficult to plan nutritional support for them. In Y2, ProVIC will ensure that the nutritional status of OVC is monitored and will design appropriate responses based on identified needs.

ProVIC will provide nutritional support to OVCs based on known cases:

- Chronic malnutrition will be addressed by nutrition education, food preparation demonstrations, etc.
- Moderate acute malnutrition – MAM (<80% wt/ht but >70% wt/ht, or MUAC between 11.0cm and 12.5cm) will be addressed in the same way and with careful monitoring to ensure the condition doesn't deteriorate and with referrals for health care where infections may be causing the problem).
- Severe acute malnutrition – SAM (<70% wt/ht or <11 cm MUAC) is an important problem that requires a rapid response. There is likely to be some SAM in communities (probably not more than 1% or 2% of children) but if we find it is a relatively more common problem, then we will help champion communities and grantees to build and plan a strongly focused intervention to address it using energy dense foods.

Based on our estimates, malnourished OVCs in all program sites will be provided with nutritional support and energy-dense food delivered by grantees operating in site. This will be done under the supervision of the ProVIC home-based care and regional care and support specialists. In addition, and in order to ensure sustainability, efforts will be made by the program, through the grantees, in collaboration with regional care and support specialists to identify within the champion communities locally available foods and encourage their production and consumption so as to ensure better diets and sustainability of supplies.

Activity 6: Provide medical or clinical support to OVC

In Year 2, ProVIC intends to support OVC access to medical and clinical care services. This will be linked to work we do under HSS and the PLHA mobilization to strengthen referral linkages. Based on the needs and availability, money will be provided to support treatment costs for some OVC via grantees. Targeting criteria and a system for administering the payments with clear accountability to communities will be developed. In the meantime, we will ensure discussion within champion communities to ensure sustainability for this kind of support in future years.

Based on our estimates, OVC needing medical or clinical care will be supported in accessing treatment from appropriate health centers by the grantees based on the mapping of service providers in each champion community. Each grantee will make a provision for this activity in its budget and will establish an agreement with existing service providers to give care and treatment to concerned OVC.

Activity 7: Provide financial support to OVC income-generating activities

During Year 2, vocational and professional training will be provided to 1000 OVCs. Out of these, at least 200 will be trained in a trade for a period not exceeding 10 months. Each Champion Community will support 25 OVC in terms of this training. The program will also create micro finance opportunities within each Champion Community. Out of these micro finance opportunities, graduating OVC will be provided with seed funding to launch their own income generating activities either as individuals or as economic interest groups. We estimated that at least 200 OVC (thus 5 in each Champion Community) will benefit from this activity. Training in micro finance will be organized in each province.

ProVIC will ensure that the following issues are taken into account in the negotiation with micro finances institutions: 1) loan from revolving fund, 2) lending systems and 3) training of beneficiaries on micro finance management.

Linkages and partnerships will be established with micro finance institutions engaged in providing micro finance in Champion Communities. This will be done with a view to facilitating access to micro credits that could benefit OVCs, PLWHAs and their families.

This activity will be done under the supervision of grantees based on the budget allocated for this line. Each grantee will include specific activities for OVC in its IGA plan.

Activity 8: Organize advocacy campaigns in each Champion community to promote community engagement, solidarity and support toward OVC

The Kinshasa based Care and Support Specialist will define the terms of reference for this activity and for the advocacy plan to be implemented by the Regional Care and Support specialists, the grantees and different steering committees of the champion communities.

The issues to be addressed during the advocacy campaigns include, but are not limited to, the following: 1) vulnerability, 2) the social role and responsibility of community toward OVC, 3) mechanisms for promoting and ensuring community solidarity toward OVC, 4) existing and potential opportunities for care and support to OVC and others. This will be done in the form of town/community meetings to allow all members of the champion community to participate and provide their input. The outcome of this exercise will be included in the community action plan as a result to be achieved by the end of the current planning cycle.

The program will seek the participation of UNICEF, MINAS, Ministry of Gender and Family, Global Fund, PNMLS, Foundation M'Zee Kabila, Save the Children and other partners and stakeholders concerned with OVC issues, and promoting child wellbeing.

Activity 9: Ensure social and legal protection for OVCs

In Year 2, the PEPFAR Child Status Index will be promoted and disseminated among key stakeholders in all ProVIC sites. 4000 copies of the index will be made available and distributed for utilization in Champion Communities through the steering committees. The Kinshasa based Care and Support Specialist will work with the Community Mobilization Specialist as well as with ProVIC Regional Care and Support Specialists to ensure effective implementation of this activity. The different clubs in champion communities such as Youth Clubs, Married Couple Clubs, and Street Kids' Clubs will be fully involved in the dissemination and utilization of the index.

Activity 10: Undertake good practice audit of care, support and protection services for OVCs

ProVIC will develop a methodology for conducting audits within defined areas on care, support and protection services available to OVC. This will look at all aspects of the care and support spectrum, as well as child protection issues, and will assess quality, access issues and service gaps in comparison with recognized and evidence-based good practice.

The methodology will be developed and field tested by a ProVIC and NGO partner team under expert guidance. The team will then apply the methodology in all implementation areas. The results will inform care and support plans and delivery.

Year 2 milestones

- National workshop held on the child to child approach.
- Advocacy campaign organized in each champion community.
- 1000 OVCs receive vocational and professional training.
- 200 OVCs supported with income-generating activities.

Intermediate Result 3: Strengthening of health systems supported

Overview and strategy

The health systems strengthening and human capacity development component improves the quality of service delivery in HCT and prevention, PMTCT, and care and support by strengthening the capacity of the community to engage on HIV/AIDS issues, improving the capacity of existing health systems and government institutions at the national and provincial levels, and strengthening the capacity of local NGO's and PLWHA networks to ensure effective implementation of activities. The improvement of services offered focuses on different levels: 1) the individual in order to instill a sense of personal responsibility, 2) the family for support and continuity of care, 3) the community to organize and support community-based services and 4) the health centers to ensure sustainability and reliability of interventions.

At the national level, the component provides support in the development of norms and guidelines to PNLs, MINAS, PNMLS, and Ministry of Gender and Family. At the provincial level, ProVIC supports the decentralization of health services management by transferring skills and knowledge to the provinces, strengthening the capacity of government services (Ministry of Social Affairs, PNLs, PNMLS, Ministry of Gender and Family), and improving

coordination among agencies and partners. In Year 2, this component will continue to focus on helping the health system provide quality services to PLWHA, OVC and the general population, including through joint supervision with PNLS, MINAS, and PNMLS, and with a focus on incorporating gender issues into planning.

To implement the project's core strategies such as champion communities, community-based care and support, and to provide other HIV/AIDS services, ProVIC works in collaboration with local implementing NGOs within the targeted health zones. One of our core strategies in this component is to identify skills and knowledge gaps and address those through capacity building. In Year 1, a map of NGOs' activities was developed for ProVIC Health Zones in order to strengthen the linkages between communities and health facilities, which, have been working with less synergy. This will facilitate the accessibility, utilization and appropriation of existing social, health and HIV services.

The collaboration with other USAID funded projects or programs will be maintained and consolidated, in particular with PSI, MSH/SPS, the new MSH Integrated Health Project, and Health Systems 20/20. The collaboration and coordination with other international, national and local partners working in the fight against HIV/AIDS, will also be consolidated in order to leverage support and benefits for service beneficiaries.

The HSS component has three sub-intermediate results:

Sub-IR 3.1: Capacity of provincial governments' health systems supported

Sub-IR 3.2: Capacity of NGO providers improved

Sub-IR 3.3: Strategic information systems at community and facility levels strengthened

Sub-IR 3.1: Capacity of provincial government health systems strengthened

Activity 1: Develop a capacity-building plan for the provincial government

Following on the capacity needs assessment undertaken in year one and in order to address identified gaps, the program will finalize the capacity building plan, and support its implementation in the four provinces. The plan for the development and the reinforcement of the capacity of the provincial governments is aimed at improving their capacity in the domains of: data collection, management, coordination, monitoring, supervision and leadership. Prior to implementation, the finalized plan will be shared with concerned structures and provinces and discussions will be held with each partner to prioritize the needs and determine gaps to be addressed with the support of ProVIC and by other partners. Once the priority interventions are identified, ProVIC will address them through training, coaching, on-site support, or other ways as determined.

Activity 2: Support MINAS in developing training materials for OVCs

MINAS is currently lacking appropriate training materials to guide partners providing services and support to OVC. The HSS component will support MINAS in the development of training curricula and related materials in collaboration with implementing NGOs partners and others such as UNICEF, PNMLS, and PNLS. This will be done through a 6 day workshop in Kinshasa will include 2 representatives of MINAS from each province, and representatives from each of the partners listed above.

Activity 3: Conduct integrated trainings for service providers in selected champion community areas

Capitalizing on the experiences of year one, the project will provide further support to the provincial PNLS offices to conduct training in the integrated package of services for health care service providers from facilities and community-based organizations. The collaboration with MSH/SPS will be sustained and an MOU will be signed between the two parties to ensure regular supervisions of the trainees in commodities and drug management.

Activity 4: Support joint supervision and coordination meetings with government partners

Quarterly joint supervisions of service providers and reviews of activities will be conducted in each province with government partners (PNLS, PNMLS, MINAS,). The aim of these reviews is to identify weaknesses and address them, to monitor the quality of services and the level of accomplishment of the activities in HCT and prevention, care and support, and PMTCT.

Activity 5: Ensure service delivery is appropriately reaching MARPs and other marginalized populations

As part of our efforts to ensure quality services, ProVIC will evaluate the extent to which our sites are adequately serving most at risk and marginalized groups (victims of GBV, MSM, CSW, and other MARP groups, PSW, PLWHA, etc) in health centers. The quality of services and the capacity for outreach will be regularly monitored and assessed by ProVIC regional staff in conjunction with PNLS and PNMLS during the quarterly supervision visits. These supervisions will be supplemented by discussions within the Champion Communities to identify obstacles to access for the identified groups, particularly those that relate to stigma and discrimination for PLWHA and victims of sexual and domestic-based violence. Based on our findings, we may design trainings or one on one support for providers at the facility level in order to address identified barriers to access.

Activity 6: Identify feasible health financing options to integrate with champion communities

In order to improve access to health services for PLHWA, OVC's and other vulnerable groups, and to ensure sustainability, we will engage a consultant to explore creative community-based health financing options which would help support health services for the community, PLWHA and OVC in particular. The consultant will write up these options and the project will determine which ones could be piloted in Champion Communities and the details of where and how. This has the potential to create a basis for providing sustainable health services to PLWHA and OVC. This exploration will also examine issues such as risk-sharing and the mobilization of resources and savings.

Activity 7: Reinforce the capacity of health centers to properly manage the handling and disposal of bio-medical waste

In accordance with the generally accepted principles of environmental management, the project will include a training module on bio-medical waste management in the integrated training programs. The curriculum will address the challenges and best practices for bio-medical waste management across the different services within prevention, care and support and PMTCT. It will also address this issue at the health facilities, at the community level and for home based care.

Year 2 milestones

- Plan for reinforcement of the capacity of provincial governments finalized and rolled out.
- Support for the development of training manuals for OVCs and PLWHA provided.
- 400 service providers trained.
- Joint Supervisions and the organization of the quarterly reviews in provinces.
- Both studies completed and fed into program development.
- Issues of stigma and discrimination addressed in the care and treatment of specific groups. This issue is related to the quality of services, how users are satisfied and what is the perception of service providers about the specific group.
- Identification and determination of options for financing of health services in champion communities.
- Biomedical waste management is integrated into service provision training.

Sub-IR 3.2: Capacity of NGO providers improved

Activity 1: Build the technical capacity of NGO partners

In Year 2, the technical, managerial, and financial capacity of NGOs partners selected to receive ProVIC grants will be assessed using tools developed by PATH and the IHAA. The gaps identified will be addressed through training provided to grantees and included in a capacity strengthening plan which will be used during the supportive supervisions. The HSS specialist will work with grants managers and the technical staff to carry out this activity which will take place as part of the grants process with partners.

Milestones

- Capacity of prospective grantees strengthened to meet requirements.
- Grants awarded to implementing partners.

Sub- IR 3.3: Strategic information systems at community and facility strengthened

Activity 1: Make available data collection tools to NGO partners

Denise Ndagano and the Regional M&E Specialists will work with M&E focal points from implementing partners to ensure the M&E data collection tools are properly used in program to produce required reports.¹ Each M&E specialist is responsible for his/her respective province, conducting monthly site visits to each IP; more frequent visits may be required of new IPs. The purposes of these initial visits are to review IP information systems, as well as to explain and ensure understanding and use of ProVIC's data collection tools and reporting requirements. This activity is an essential step toward project progress: in order to prepare for the upcoming M&E training of trainers (TOT), the team must have visited all current IPs and finalized the data collection/reporting tools.² In doing this, pertinent and basic understanding of these tools is required to design the M&E training in January 2011. Follow-up visits to monitor IPs with ensure that information reported is correct, complete, and on time. The RDQA techniques will be incorporated into monthly monitoring visits, beginning in the second quarter of project Year 2.

¹ This activity is a continuous process; when ProVIC engages new IPs, the project team would then need to introduce tools, etc.

² Tools should have incorporated family planning, TB, and gender aspects by the end of the first quarter.

Efforts will be made to harmonize data collection tools to reflect national data needs. We anticipate that the Government of the Democratic Republic of Congo (GDRC) will follow the World Health Organization's (WHO's) new antiretroviral (ARV) guidelines within the next month. ProVIC will then need to revise its PMTCT tools to reflect any changes to ARV medications listed in these guidelines. The M&E team will also integrate family planning, gender, and tuberculosis (TB) into current data collection and reporting tools.

Year 2 milestones

- Harmonized data collection tools are available to implementing partners.

Activity 2: Train provincial actors (at the health facility and community levels) in M&E

To support the project M&E system including the reporting system, ProVIC will conduct a cascade training of trainers (TOT) and training of providers (TOP) for the staff of implementing partners directly involved in the M&E activities. We will focus on providing skills to M&E focal points to ensure delivery of quality data processing for the project. PATH's DC-based M&E specialist will work closely with the ProVIC M&E team to develop a training guide for the M&E TOT focused on ProVIC M&E systems (e.g., ProVIC's requirements regarding information needs per component, and per clarifications from The US President's Emergency Plan for AIDS Relief (PEPFAR) indicators and reporting tools, etc.).

The first training is anticipated to take place in Kinshasa in January 2011, with participants from the national and provincial National Multisectoral AIDS Program (PNMLS), Ministry of Social Affairs (MINAS), and selected representatives of IPs and health structures. Subsequent trainings will be held in the other three provinces in January 2011. Participation of representatives from PNMLS, the National AIDS Control Program (PNLS), and MINAS in facilitating these workshops will also be essential. PATH's DC-based M&E specialist will participate in and evaluate the aforementioned workshop in Kinshasa. Working with the M&E team and others, the content of this training may be revised as necessary for the subsequent regional trainings. The January short-term technical assistance (STTA) would coincide with ProVIC team trainings surrounding routine data quality assurance tools.

Year 2 milestones

- ProVIC M&E manual finalized.
- Training conducted at national and provincial levels.
- M&E focal points identified trained (at the facility/community levels).

Activity 3: Strengthen quality assurance (QA) system

Throughout the second year, relevant project technical staff (M&E specialist Denise Ndagano, health systems strengthening specialist Dr. Zambite, PMTCT specialist John Ditekemena, HCT specialist Voulu Makwelebi, and regional M&E specialists) will identify weaknesses or issues in data collection tools and data quality. PATH's DC-based M&E expert, Anh Thu Hoang, will develop tools to assess local service providers against existing national norms. Facilities will be trained by the project staff in the self-evaluation process to identify gaps and develop action plans. This activity will be coordinated with local and regional PNLS, PNMLS, and MINAS staff so that they are fully participating in quality improvements and in better reporting. Internal data audit will be held every semester in provinces during the supervision.

Some examples of quality improvements that may be targeted for HCT include rapid testing, counseling, and WHO protocols and the development of job-aids, self-evaluation tools, and peer-review tools. Project staff will also look at on-site supervision mechanisms to make sure that regular performance assessment is occurring, feedback is provided through client exit interviews, and that PNLs is supported in their evaluation role. Activities may include training provincial PNLs teams in assessment and feedback protocols. PATH's DC-based M&E expert will also provide support to develop assessment tools and/or QA norms. Dr. Zambite will be responsible for supervision of these activities, but implementation will be carried out by other relevant project technical staff.

Activity 4: Support M&E reporting systems

M&E specialist Denise Ndagano and regional M&E specialists will respectively participate in the national and provincial M&E task force to provide on-going support as appropriate for necessary revisions to the M&E framework and plans. Ms. Ndagano will ensure dissemination and training as necessary to provincial government actors, and our Regional M&E Specialists, we will work with local and national actors to ensure adequate flow of strategic information between the local and national level. Ms. Ndagano, with support from PATH's DC-based M&E expert, will continue to identify gaps and develop means for bridging those gaps appropriate tools and mechanisms to improve M&E reporting and feedback loops.

To allow the M&E team to easily retrieve and use information on orphans and vulnerable children (OVCs) in particular, as well align project indicators with national indicators, we must develop a database for ProVIC. Among the important functions of this database is the alignment of project indicators with those of the national system, which uses the Clinical Research Information System (CRIS). We anticipate hiring a local consultant to develop this database and provide a brief orientation to the M&E team on how to use the system.³ Appropriate mechanisms are in place to ensure not only quality data but also adequate information flow and feedback to the system for its refinement as necessary.

Year 2 milestones

- Data quality improvement strategies identified.
- Internal data audit conducted twice a year.
- Trainings conducted at national and provincial levels in national M&E.

Activity 5: Support M&E systems in champion communities

PATH's DC-based M&E specialist will provide inputs into the system design and developed tools and will take the lead in adapting monitoring and reporting tools for CCs, working closely with the CC coordinator and Kinshasa M&E specialist to finalize these tools. Regional M&E Specialists will work with community counselors and NGOs to design quality assurance and performance assessment tools for the care and support component. The ProVIC M&E team will participate in quarterly monitoring visits to Champion Communities, and the DC-based M&E specialist will to conduct monitoring visits during her STTA (i.e., field visits). The ProVIC M&E team will provide the support needed to evaluate champion communities at the end of their project life; these evaluations are expected to occur at the end of Year 2 or during the first quarter of Year 3.

³ Efforts will be made to recruit locally for the consultant; however, PATH also has appropriate in-house staff who could provide this technical assistance if necessary.

Year 2 milestones

- Monitoring tools for champion communities developed.
- Action Plan developed in champion communities.
- Data reporting system functional in champion communities: dissemination and utilization of data in decision-making.

Activity 6: Provide support to/for M&E activities at the national and provincial levels to PNMLS, PNLs, and MINAS

ProVIC will continue to provide support to PNLs, PNMLS, and MINAS in Year 2. With PNMLS, work begun during Year 1 to evaluate the national M&E strategy and framework and develop a strategy incorporating ProVIC's information needs will continue into the first quarter of Year 2. Once in place, PNMLS must then implement the new M&E strategy and framework (e.g., by training PNMLS representatives and partners at the national and provincial levels). ProVIC will also support PNMLS in undertaking a national AIDS spending assessment (NASA) of partners in the fight against HIV/AIDS. Through the NASA, PNMLS will have national estimates of resources and spending related to AIDS efforts in the DRC (RESA).

MINAS will continue with its work with the OVC tools that were developed in the last quarter of Year 1. ProVIC will support the piloting of these tools in two of its provinces, as well as the establishment of a national database with OVC information. ProVIC and MINAS will also conduct joint monitoring missions to increase M&E synergies, and in turn, efficiencies and impact.⁴ Another objective of these missions is to build national and provincial MINAS capacity. It is anticipated that PATH's DC-based M&E specialist will accompany ProVIC and MINAS on one of the joint monitoring visits.

Year 2 milestones

- Provincial data available at the national coordination level on a regular basis.
- New OVC tools piloted in two provinces.

IV. CROSS-CUTTING ACTIVITIES

Monitoring and evaluation

As detailed in Result 3(health systems strengthening, Sub-IR 3.3), ProVIC's Year 2 M&E activities center around building strong M&E systems—those of both local implementing partners (IPs) as well as state-run institutions at the provincial and national levels. In order to adequately support our project partners, the ProVIC M&E system must be a strong one, and the four M&E specialists will be proactive to accomplish the myriad tasks at hand. Every quarter, each M & E specialist will develop an operation plan detailing the monitoring/follow-up visits and other important M&E activities for his/her respective province. Results and lessons learned will systematically be shared and discussed with team members to ensure that revisions are made if necessary.

⁴ Among the potential objectives of joint missions is to verify the status of OVCs. Results from these missions can be promptly shared/discussed at the provincial and national levels to then allow for more immediate identification and addressing of potential issues or concerns.

PATH's DC-based M&E specialist will work closely with the ProVIC team throughout Year 2 to provide necessary technical support and coordination. She will provide hands-on training and follow-up support on routine data quality assessment (RDQA) to the team for incorporation into their monthly monitoring visits as necessary. Ascertaining quality data will be one of the DC-based M&E specialist's main tasks during the three planned visits to the field. She will also work closely with the team to review Year 2 activities and plan for Year 3 in the third quarter of Year 2. Consistent technical support from PATH will help strengthen and reinforce ProVIC's M&E system.

Gender

Gender is a critical component of the ProVIC project, both in terms of ensuring equal access to services and also in terms of contributing to overall project results. Gender-based vulnerabilities to HIV infection affect the design of prevention strategies. Differences in health-seeking behaviors between men and women mean that using a gender lens is critical to designing appropriate activities and achieving targets.

A gender specialist from PATH conducted an analysis of the gender dynamics relevant to implementing HIV/AIDS activities and to design a comprehensive gender strategy. The specialist worked with each component leader to design specific activities or modify existing ones to fully account for the specific gender issues identified. These recommendations have been integrated into activities and are reflected in the work plan.

A conceptual framework, which highlighted overall messages and approaches for integrating gender considerations into ProVIC included the following:

- Gender norms, GBV and gender inequity greatly impact access and demand for health services, negotiation and power dynamics in relationships and overall health outcomes.
- Integrating gender is a strong way to improving health outcomes & achieve the highest health standard for women, men and children in all communities.
- It is about the men too – not just the women! In fact it is often more about the men and the need to engage them in addressing norms that lead to increased risk behavior.
- By supporting gender equity and violence free communities, we are supporting increased health outcomes and development for everyone – not just for women. Men are partners with women in supporting health for everyone in the community. When we support equality and equity, women are better equipped, couples are happier and healthier, everyone benefits!
- Male involvement in PMTCT so that male partners support women's testing and follow up with mothers and babies.
- Women are more likely to seek HCT than men so importance of designing messages and strategies that encourage men to seek counseling and testing.
- ProVIC can use the Champion Community framework for encouraging increased support for gender equity. ProVIC's message should highlight a Champion Community as one that:
 - Supports the right to full access to services for all members regardless of sex, HIV status or other factors.
 - Respects and treats all its community members equally and equitably.

- Promotes the full development of all its members – and addresses any challenges or impediments to such development.
 - Does not support violence in any of its manifestations and commits to being proactive in preventing and responding to such violence.
 - Encourages “champion men” who support equality and speak out against violence.
 - Gender-based violence, including inter-personal violence as well as stranger sexual violence is rooted in deep seated gender norms and power dynamics which need to be challenged at the community level. The responsibility for such violence is *everyone’s* responsibility.
- Gender norms need to be addressed at the community as well as the service provider level – stigmatizing, discriminatory attitudes and behaviors need to be challenged and transformed into positive, health-promoting ones.

This conceptual framework, coupled with programmatic tools introduced by the gender specialist, formed the basis for in-depth conversations to incorporate concrete and ‘doable’ activities into each component to address gender related challenges into the Year 2 work plan.

Family planning

In our work plan, we have integrated family planning activities into each intermediate result to ensure that this crucial link between HIV/AIDS services and family planning services is made. Thanks to the outcomes of the work done by a family planning consultant in Year 1, a comprehensive approach to integrate family planning in program activities will be fully implemented. The Community Mobilization Specialist will be leading this process along with the integration of gender considerations in Champion Community activities. Some important links that we will ensure are made through implementation include the following:

- Integrate family planning in to HCT so that counselors have the training and resources to give advice and make referrals.
- Work with PSI to bring the family planning products and marketing into champion communities and other community partners.
- Integrate family planning products and counsel into the care package for PLWHA
- Support local NGO partners to develop their own family planning resources and strategies.

Grants management

In year one of ProVIC grants were concluded with organizations that had received funding from either Catholic Relief Services (CRS) or Family Health International (FHI) to ensure a continuity of services particularly in the areas of Care and Support for Orphans and Vulnerable Children and People Living with HIV/AIDS. In addition to these grants and other grants that funded HIV Counseling and Testing (HCT) activities, ProVIC undertook direct funding activities with Hôpitaux Générales des Références (HGRs) and Centres de Santé des Références (CSRs) to fund both HCT and Prevention of Mother to Child Transmission (PMTCT) activities. Other direct funding activities were conducted with local NGOs as well.

After the publication of our Request for Grant Applications (RFA) in mid April 2010, ProVIC invited 74 groups out of over 450 submitted concept papers to participate in regional proposal writing workshops. Subsequently, after conducting capacity risk assessments, ProVIC initially pursued completing grant agreements with 21 of these groups. This strategy was intended to bring more partners into a grants process that, previously, had been dominated by only a few large local NGOS. After consultations with USAID, however, it was agreed that a more focused strategy with larger impact grants was more appropriate and that a smaller number of grantees, at least initially, would be more appropriate

For Year 2, ProVIC plans to continue direct funding activities with HGRs and CSRs. Our grants strategy, however, will evolve to fully integrate the Champion Communities strategy. The project will evaluate applicants and award grants based on the implementing partner's ability to apply the Champion Communities model while offering the range of services ProVIC supports: HCT, PMTCT, care and support of PLWHA and OVC's. In a few instances, two organizations may need to partner in a given area to provide the complete package of services, but they will be linked by the common champion community approach so that beneficiaries experience a seamless package of comprehensive support.

We will limit the number of grants to, initially, ten to fourteen local NGOs that have responded to our Request for Applications and have undergone training in proposal development and demonstrated sufficient technical, administrative and financial management capacity. These groups have been selected and will be directed to refine their existing applications to incorporate the Champion Community model and to demonstrate how their activities fall with the ProVIC zones of intervention. These "preselected" groups present a regional and technical diversity that will allow ProVIC to achieve results in all technical areas.

We are currently considering pursuing grants with the following local NGOs in Year 2:

In Kinshasa

- Amo Congo
- Femme Plus
- Réseau National des Organisations d'Assise Communautaire des Groupes de Support des Personnes Vivant avec le VIH/SIDA (RNOAC_GS/PVVIH)
- Progrès Santé Sans Prix (PSSP)
- Teaching Individuals and Families Independence through Enterprise "TIFIE Humanitarian"
- Society for Women Against Aids in Africa (SWAA)

In Bas Congo

- Amo Congo
- Eglise Kimbanguiste de Kinzau Mvute/ Centre Maman Kinzembo (CEMAKI)
- Jeunesse Active pour le Développement Intégré et lutte contre le SIDA (JADISIDA)

In Katanga

- Amo Congo
- Bureau Diocésain des Œuvres Médicales (BDOM) Kolwezi
- Bread and Knowledge Too (BAK Congo)
- Organisation non Gouvernementale Lique a Vocatoin Socio-Economique du Congo (OLESEC)

- World Production

In South Kivu

- Femme Plus
- Association de Lutte pour la promotion et la protection des droits de la Femme et de l'Enfant (ALUDROFE)
- Association Cooperative en Synergie Feminine (ACOSYF)
- Society for Women Against Aids in Africa (SWAA)

Discussions are currently underway with these 14 groups to begin refining their existing applications to include the integration of the Champion Community approach. We will provide orientation sessions in October and early November and expect updated applications shortly thereafter. We would then expect to present formal grant applications shortly thereafter, with implementation beginning during the later stages of the first quarter of the year.

Training

Training is a key component of our project activities as we budget under this category all meetings, consultations, stakeholder workshops, etc in addition to standard skills training. Therefore, the project uses training both at the national level with government partners to validate approaches and seek their input and ideas; with our NGO implementing partners to train them in specific approaches such as Champion Communities or positive living for PLHA; with providers in health facilities on topics such as quality improvement or other best practices; and with regional and local government officials in supervision of quality HIV/AIDS services. Training will often use a cascade approach where NGO partners are trained to then train community-based groups who can then disseminate the information in their communities. Each activity plan shows how training will be used in that component to contribute to project results.

Procurement

The project has an \$800k procurement budget under the SAF to fund the purchase of commodities to implement HCT and care and support activities. When this budget was conceived, it was understood that a basic level of services and associated commodities, were available through either public sector facilities or faith-based facilities and that the project's role would be focused on improving those services through technical assistance and capacity building; linking communities to services and creating demand through the champion communities approach; and improving quality. It has since become clear however that the targeted project sites depend completely on external support to offer services. For example, hospitals targeted for HCT cannot do HCT if they are not provided with all the inputs including gloves, test tubes, pipes, etc. This was not foreseen in the project budget yet to successfully implement project activities, these necessary commodities must be purchased by ProVIC.

Further, USAID also requested that PATH procure ARVs for PMTCT, palliative care drugs and HIV/AIDS diagnostic test kits for partners (i.e. grantees) and health facilities included in the project's health intervention zones, since meeting the project objectives would be impossible without these commodities. This was not in the original Scope of Work and the project had not planned on procuring pharmaceuticals, since it was understood that ProVIC would leverage donations for these from partners, such as the Global Fund and Clinton

Foundation. However, it was immediately apparent upon project start-up that the procurement of ARV's, in addition to test kits and related commodities would be necessary to support project activities since the pharmaceuticals we had expected to leverage from donors, were in fact already programmed and were facing a supply shortage.

In order to maintain project momentum, and at the request of USAID, ProVIC therefore purchased the pharmaceuticals, lab supplies and other basic commodities necessary to conduct planned activities. As a result, we have already spent most of the \$800k originally planned for procurement.

While ProVIC will continue to seek opportunities to leverage support for these resources from partners for future commodity replenishments, and is carefully managing its budget to identify savings, we will need to pursue the conversations already started with USAID on how to address this budgetary shortfall in the longer term.

Environmental compliance

In year one ProVIC developed and implemented a plan and guidelines for handling hazardous biomedical waste generated by HCT, PMTCT and Care and Support services and activities. In addition to training HCT facilities in Kinshasa and Matadi in hazardous biomedical waste management, regular supervision visits were conducted to ensure compliance among service providers and partners. Furthermore, three incinerators were rehabilitated and small equipment provided to ensure effective disposal of the biomedical waste.

It was quickly apparent that environmental impact mitigation and waste management is not the priority for the most health care structures and providers. Communities, as well as the private sector, are unaware of the risks associated with biomedical wastes. National norms exist and clearly provide guidance on the collection, handling, conservation, storage, transportation and elimination of hazardous biomedical wastes but their implementation is far from the acceptable level.

In Year 2, therefore, ProVIC intends to mobilize and educate communities, the private sector and service providers around the issues related to handling biomedical wastes. The capacity of service providers in health structures, communities and home based care will be strengthened. The program plans to rehabilitate incinerators in champion communities and provide special garbage and other supplies needed to ensure a proper handling of biomedical wastes. In addition, we will ensure that each grantee will be held to USAID's environmental impact mitigation standards, and that a portion of their budget will be specifically allocated to this purpose. The ProVIC team, in collaboration with PNLs and health medical teams in the health zones, will also conduct regular follow up and supervisions to ensure the compliance to norms and guidelines pertaining to the management of biomedical waste.

IV.ANNESES

Annex A. Detailed Year 2 activity plan (see attachment)

Annex B. Partner and collaboration matrix

| ProVIC Cooperative Framework Focal Points and Partners | | | | | | | |
|---|---------------------------|---------------|--|--|--|---|------------------------------|
| Key partner | Contact | Focal Point | Purpose of collaboration | Type of information | Coordinating mechanisms | Expected results | Frequency |
| PNMLS | Luke Kanyimbo | Mbella/Denise | Strengthen coordination capacity, support the development of policies, guidelines | Evolution of disease in project sites, maps / intervention, policy / standards / standard, gap, tools, program | Meeting coordination, development, joint planning with M&E unit | Harmonization of collection tools, updating policies and guidelines | Monthly, quarterly, annually |
| | Dr. Luc Kanyimbo Tshibaka | Elysé | Strengthen coordination capacity, support the development of policies, guidelines, support NGOs and CBOs | priority needs, strategies, interventions, guidelines | Session work coordination meeting with M&E unit component support to NGOs and CBOs | Development of capacity building plan | Monthly, quarterly, annually |
| | Dr. Kawunda | Voulu/Elysé | Support development of sectoral policies, support updated research plan on HIV/AIDS in DRC | Sectoral policy | Session work coordination meeting with focus on prevention | Policy review of DCIP; participation in at least a baseline study on HIV/AIDS | Monthly, quarterly, annually |
| | Drs. Mboyo and Tshibaka | Alioune | Support development of sectoral policies | Sectoral policy | Session work coordination meeting with focal point of care | | |
| | Drs. Mboyo and Tshibaka | | | Sectoral policy | | | |

| | | | | | | | |
|--------------|---|----------------|---|---|---|---|------------------------------|
| PMLS | Dr. Okenge, Dr. Audry and Bijou | Mbella/Denise | Strengthen coordination capacity, support development of policies, guidelines | Evolution of disease in our sites, maps/intervention, policy/standards, gap, tools, program priority needs, strategies, interventions, guidelines | Meeting coordination, development, joint planning with M&E team | | Monthly, quarterly, annually |
| | Dr. Freddy Salumu | Elysé | | | | | |
| | Drs. Alimasi | John/Mitterand | Strengthen coordination capacity of PMTCT partners, support the development of policies, guidelines for PMTCT | Changes in our PMTCT sites, maps / intervention, policy /standards, gaps, tools, program priority needs, strategies, interventions, guidelines | Meeting coordination, development, joint planning, M&E activities | | Monthly, quarterly, annually |
| | Dr. Makela and Aimé Bolembó | Voulu/Salva | Strengthen coordination capacity of partner VCT, support revision of VCT policy, prevention | Evolution of VCT in our sites, maps / intervention, policy /standards, gap, tools, training needs on PICT | Meeting coordination, development, joint planning, M&E activities | | |
| | Dr. Freddy Salumu, Jacky Kiamenga and Ekili | Alioune | Strengthen coordination capacity of partner care and support, support implementation of policies on management of PVP, care and support | Evolution of support for PLWHA (care and support) in our sites, map / intervention, policy / standards, gaps, tools, training needs | Meeting coordination, development, joint planning, M&E activities | | |
| MINAS | Eric Mpiana, Dir. Botiho | Alioune | Implement activities defined in OVC Action Plan, determination of groups at high risk Definition of OVC Package | Track OVCs in project sites, maps/interventions, policy/standards, gaps; development of tools, MINAS priority needs, strategies, guidelines | Meeting coordination, focus groups, joint planning | Definition of Minimum Package for OVCs, align data collection tools | Monthly, quarterly, annually |
| | | TBD | | | | | |

| | | | | | | | |
|--------------------------------|----------------------------|------------------------|--|---|--|---|--------------------|
| | Eric Mpiana and Dir Botiho | Elysé | Strengthen capacities for coordination and leadership | Gaps in normative documents, tools for monitoring & evaluation | Meeting coordination, focus groups, planning, M&E activities | | |
| School of Public Health | Prof. Dr. Patrick Kayembe | John/Mitterand | Develop research protocol, survey, baseline studies, integration sites | Reports of studies and surveys on HIV/AIDS | Meetings, information sharing, work sessions | Operational research conducted in our intervention sites | Monthly, quarterly |
| | Prof. Dr. Patrick Kayembe | Denise | | Reports of studies and surveys on HIV / AIDS | Meetings, information sharing, work sessions | | |
| | Prof. Dr. Patrick Kayembe | Elysé | | Reports of studies and surveys on HIV / AIDS | Meetings, information sharing, work sessions | | |
| | Prof. Dr. Patrick Kayembe | Voulu | | Reports of studies and surveys on HIV/AIDS | Meetings, information sharing, work sessions | | |
| PNAME | Franck Biayi, | Voulu & John/Mitterand | Develop plans for procurement and distribution facilities, laboratory testing and integration into the national system of distribution of essential drugs ASRAMA | Management of commodities | Meetings, exchange of information sessions | Establishment of efficient supply and distribution of commodities | Monthly, quarterly |
| | Franck Biayi | Elysé | Develop and implement procurement policies on drugs, comforts and laboratory tests | Reports of studies on supply facilities, medicines and laboratory tests | Meetings, exchange of information sessions | | |

| | | | | | | | |
|---------------------------------------|---------------------|----------------|--|--|---|---|--------------------|
| Ministry of Education | Ms. Jackie Basoluwa | Alioune | Collaborate in managing education and access to vocational education for OVC | Profile OVC situation with regards to education | Meetings, information sharing sessions | Provide education and assist with social reinsertion of OVC | |
| | | Voulu/Salva | Collaborate in identification, development, and process messages from CCC in specific groups and track integration agenda of HIV in EPSP curricula | Mapping of interventions, gap, tools, priority needs of program, intervention strategies | Meetings, joint planning, joint monitoring and supervision | Development of messages concerning HIV/AIDS in schools | Monthly, quarterly |
| Ministry of Gender and Family | | Georges/ Salva | Mainstream gender in program activities | Policies, guidelines on gender, tools, strategies | Working sessions with department, planning joint activities | | As needed |
| | | Alioune | Engage families in reintegration of OVC in overall care and fight against OVC stigma and discrimination | Policies, guidelines on gender, tools, strategies | Working sessions with department, planning joint activities | | |
| | | John/Mitterand | Advocacy for male involvement in PMTCT activities | Policies, guidelines on gender, tools, strategies | Working sessions with department, planning joint activities | | |
| Ministry of Industry and Trade | | Mbella/Alioune | Provide facilities for sale of production IGAs for PLWHA and affected families | | | | |

| | | | | | | | |
|--------------------------------------|------------------------------|------------------------|--|---|---|------------------------------------|---------------------------------------|
| Ministry of Agriculture | | Mbella/Georges/Alioune | Obtain expertise for IGA in agriculture, fishing and livestock; facilitate access to agricultural products for PLWHA and OVC | Guidelines on agriculture, livestock, fish | Working session with department, planning joint activities | | |
| Department of Land Affairs | | Mbella/Georges/Alioune | Obtaining land for IGA | | Working session, planning | | |
| Ministry of Interior | | Alioune | Protection and security of AGR and PVP and OVC | | Working session, planning | | |
| Ministry of Youth and Sports | | Alioune | Trades training in youth centers in site preparation | Policy support for youth employment policy for youth | Working session, planning | | |
| Ministry of Planning | | Elysé/ Mbella | Integrate ProVIC programs into plan's development (PRSP) | Report development process DSCR, PAP | Working session, planning | | |
| | | Denise | | | | | |
| USAID | Joshua Karnes | Mbella and team | Technical support and strategic direction in implementing program | Guidelines for USAID in implementation of programs funded by PEPFAR | Work session, planning, review | | |
| CDC | Dr. Milangu | Denise | Harmonize and provide technical support on PEPFAR indicators | Method of calculating indicators, reporting template PEPFAR | Work session | | Monthly, quarterly, annually |
| | | John/Mitterand | Collaboration: PMTCT and pediatric care | Mapping of PMTCT | Work session | | |
| MSH Integrated Health Project | Dr. Ousmane Faye/Dr. Gilbert | John/Mitterand | PMTCT, capacity building and site preparation for ProVIC | Reports of activities, Work Plan | Meetings, joint planning activities, revised mid-term, annually | Offer of standard package of PMTCT | Weekly (first 6 months), then monthly |

| | | | | | | | |
|-----------------|----------------|------------------------|---|--|--|--|--|
| | | Elysé | Strengthening health system in areas of MSH Integrated health project | Activity reports, work plan and implementation | Meetings, joint planning activities, revised mid-term and annually | | |
| | | Denise | Harmonization of management systems in data | Activity reports, work plan and implementation | | | |
| C-change | Dr. Drabo | Voulu | Communication for behavior change, social mobilization, and training | Activity reports, work plan, areas of interventions and partners, audio/visual | Joint planning, joint supervision, exchange of best practices, reports | Development of messages and audio/visual | Weekly (first 6 months), then monthly |
| | | Salva/Elysé/Alioune | TOT in our areas of intervention. Adaptation of tools of social mobilization and community champions | Plan for capacity building. Activity reports, work plan and implementation | Joint planning of activities, joint supervision, planning, exchange of best practices, reports | Achieving TOT | Weekly (first 6 months), then monthly |
| | | John/Mitterand | Develop strategies for male involvement in PMTCT services and increase traffic services | Activity reports, work plan and implementation | | | |
| MSH/SPS | Nathalie Wembo | Elysé | Durability of drug recycling, support development, drug management and other laboratory products, documenting drug policy | Reports of activities, Work Plan | Meetings, joint planning activities, revised mid-term and annually | Establishing system of drug management | Weekly (during first 6 months), then monthly |
| | | Voulu & John/Mitterand | Development Plan, supply facilities, | Reports of activities, Work Plan | Meetings, joint planning of | Development of a procurement | Monthly, quarterly |

| | | | | | | | |
|----------------|----------------------|----------------|---|--|--|--|---------------------------------------|
| | | | medicines, laboratory testing program | | activities, annual reviews | plan project | |
| PSI/ASF | Alpha Kage | Voulu & Salva | Collaboration in the identification, development, and process messages from CCC in targeted communities and social marketing of condoms. Reference to VCT | Activity reports, work plan, areas of interventions and partner's performance, audio visual, leaflets etc. | Joint planning of activities, joint supervision, exchange of reports and documentation of best practices | Reference clients in VCT, developing messages and audio visual and availability of condoms in the intervention sites | Weekly (first 6 months), then monthly |
| | Alpha Kage | John/Mitterand | Strengthening community mobilization around PMTCT sites | Activity reports, work plan, areas of interventions and partner's performance, audio/visual | Joint planning of activities, joint supervision, exchange of reports and documentation of best practices | Reference clients in PMTCT and availability of condoms in the intervention sites | Monthly, quarterly |
| UNAIDS | Dr. Christian Mouala | Denise & Elysé | Coordination of the partners, backstopping the national framework for the fight against HIV/AIDS | Guidelines, collecting UNGASS indicators | Working meeting, exchange of information | | Monthly, quarterly |
| | Prof. Chirume | Gilbert | Collaboration in the implementation of activities in central Matonge IST | Harmonization of partners involved in the center IST Matonge | Joint planning, joint supervision, exchange of reports and documentation of best practices | Effective coordination of stakeholders and interventions at the center IST Matonge | Monthly, quarterly |
| WHO | Dr. Casimir Mazengo | John/Mitterand | Coordination on drug management, development of | Procurement policies and management of medicines and other | Working sessions, exchange of | Management standards and guidelines | Quarterly |

| | | | | | | | |
|---------------|---------------------|----------------|--|---|---|--|-----------|
| | Dr. Casimir Mazengo | John/Mitterand | standards | pharmaceutical products, standards and guidelines | information and reports, participation in the creation and operation of national coordination mechanism for management of HIV/ AIDS medicines and laboratory products | discounted drugs | Quarterly |
| | Dr. Etienne Mpoyi | Denise | Data management in our intervention sites | Tools, data, definition of indicators | Working meeting, exchange of information | | |
| | Dr. Issaka Compaore | Voulu | Implementation of effective prevention strategies in the intervention sites | Policy of universal access to prevention | Working sessions, exchange of information, participation in strategic meetings | | |
| UNICEF | Mr. Florent Booto | Alioune | Information and collaboration on PMTCT and OVC, MII, and access to drinking water programs DISPLACED | Share experience in PMTCT and OVC, report, mapping of interventions | Meetings, work sessions | Harmonization of collection tools and define minimum package for OVC | Quarterly |
| | Dr. Gertrude | John/Mitterand | Coordinator's activities in PMTCT intervention sites | Report of activities, mapping of interventions | Meetings, work sessions, task force | | |

| | | | | | | | |
|-------------------|----------------|-----------------------------------|---|--|--|---|--------------------|
| UNFPA | Dr. A. Matondo | Voulu/Salva | Supply of contraceptives and condoms for FP in our intervention sites. Harmonization of interventions in Central Matonge IST | Sharing experiences and PF condoms and community mobilization, mapping of interventions | Meetings, work sessions | Availability of contraceptives and condoms in intervention sites | Quarterly |
| UNDP/GFATM | Yves | Mbella, Georges, Alioune & Denise | Working in synergy and harmonization of interventions on management of OIs and ART (advocacy for the availability of ARVs in intervention sites ProVIC) | Mapping stakeholders and interventions in our intervention sites | Work Session, planning, trade experience reports. Meetings, harmonization of intervention programs, information exchange | Supply of ARVs and other medicines IO input to the ART. Access to best practices in the intervention sites GF | Monthly, quarterly |
| WFP | | Alioune | Kit Food Support Project of agriculture of PVP and OVC | Arrangements for access to food assistance to OVC and PPV, estimation of nutritional need of PVP, mapping of interventions | Meetings, harmonization of intervention programs, information exchange | Availability of Food for PLWHA and OVC KITS in ProVIC intervention sites | Monthly, quarterly |
| | | John/Mitterand | Food assistance to HIV positive pregnant and breastfeeding women | Estimation of nutritional needs of HIV positive pregnant and breastfeeding women and mapping of interventions | Meetings, harmonization of intervention programs, information exchange | Availability of food kits for HIV positive pregnant and breastfeeding women | Monthly, quarterly |
| MONUSCO | Dr. Diagne | Voulu/Salva | Complementarity and synergy in areas of interventions on HIV prevention | Share experience in fight against HIV and AIDS, trade reports, mapping of interventions | Meetings, harmonization of intervention programs, information exchanges | Exchange of experiences and collaboration on HIV prevention | Monthly, quarterly |

| | | | | | | | |
|----------------------------------|--------------------|-----------------------|---|--|---|---|-----------------------|
| | Dr. Diagne | Mbella/Georges | Use network of MONUSCO for implementation of activities | Mapping operations | Meetings, harmonization of intervention programs, information exchanges | Synergy | Monthly, quarterly |
| | Dr. Diagne | Alioune/Georges/Salva | Working in synergy and harmonization of interventions on gender and rights of PLWHA/PA | Their experience in fight against HIV/ AIDS, trade reports, mapping of interventions | Meetings, harmonization of intervention programs, information exchanges | Exchange of experiences and collaboration on HIV prevention, gender rights and PVP / PA | Monthly, quarterly |
| UNIFEM | Jean Claude | Salva/Georges | Increase the participation of networks of women in control activities, reduce vulnerability of women | Mapping interventions and partners | Meetings, harmonization of intervention programs, information exchanges | Involvement of women's networks in the activities | Monthly, quarterly |
| Clinton Foundation | Dr. Esther Bamenga | John/ Mitterand | Facilitate support of pediatric cases of HIV / AIDS by ensuring availability of inputs and products and laboratory equipment | Mapping of interventions, information on inputs in early detection of HIV in children, tours of drug supplies and conveniences | Meetings, joint planning activities, revised mid-term and annual | Early diagnosis and pediatric care provided in our site preparation | Monthly and quarterly |
| | | Alioune | Facilitate support for medical PVP to ensure availability of second line ARVs | Documentation on access to medicines | Meetings, joint planning activities, revised mid-term, annually | Availability of second-line drugs | Monthly and quarterly |
| Global Rights Human Right | | Alioune | Contribute to the extension of law on sexual violence and protection of PVP / PA, strengthening capacities of partners in protection of | The areas of intervention tools, experiences, and best practices | Meetings, joint planning activities, revised mid-term and annual | Extension of law on sexual violence and protection of PVP / PA, the capacity of partners in | Monthly and quarterly |

| | | | | | | | |
|---------------------------------|---------------------|-----------------------|--|--|--|--|-----------------------|
| | | | PVP/PA | | | protection of PVP/PA is enhanced | |
| Hellen Keller Foundation | | Alioune | Facilitate nutritional management of PVP | The areas of intervention tools, experiences and best practices | Meetings, joint planning activities, revised mid-term and annual | Nutritional support of PVP provided | Monthly and quarterly |
| UNC | Vicky | John/Mitterand | Collaboration and support in PMTCT in Kinshasa and Bas Congo, collaborative studies related to PMTCT | Activity reports, work plan, list of maternities, project proposals, publication of research and success stories | Meetings, joint planning activities, revised mid-term and annual, regular field visits | Complementarity and implementation of comprehensive package of activities in PMTCT sites | Monthly and quarterly |
| Heal Africa | Judith / Dr Jo Lusi | Salva/Georges/Alioune | Build mechanism for community-based capacity building Sharing experiences on the care of OVCs. | Progress Report approach to comprehensive care of OVC, approach to gender | Meetings, joint planning activities, field trips | Capitalize on best practices | Quarterly |
| GTZ | Dr. Jo Bakwalufu | Elysé | Knowing mapping of interventions, gap, complementary activities, synergy | Experience in fight against HIV/ AIDS, trade reports, mapping of interventions | Meetings, harmonization of intervention programs, information exchange | Complementary activities in fight against HIV/AIDS | Monthly |
| MSF / MDM | | Voulu/Alioune | Collaboration in proper management of STIs according to syndromic approach and IO | Their experience in fight against HIV and AIDS, trade reports, mapping of interventions | Meetings, exchange of information | Complementary management of STIs | Quarterly |

| | | | | | | | |
|-------------------------------|-----------------|---------------------|--|---|---------------------------------------|--|-----------------------|
| ACF | | Alioune Salva/Elysé | Facilitate nutritional management of PVP, capacity building of community volunteers on PEC nutrition | Report of activities, results of the pilot study on nutritional management of PVP | Meetings, exchange of information | Capitalize on best practices | Quarterly |
| CORDAID | | Alioune | Complementarity and synergy in areas of interventions in community care | Mapping interventions their experiences in community care of OVC and PVP | Meetings, exchange of information | Development of complementarity and synergy in action | Monthly, quarterly |
| | Ariane | Denise | Alignment of tools for data collection | Tools, activities report | Meetings, exchange of information | Tools for gathering information harmonized | Quarterly |
| Private Sector/FEC/Sky | | Voulu | Enhancing prevention in workplace | Report of activities, mapping interventions and stakeholders | Meetings, exchange of information | Preventing HIV infection in workplace | Monthly, quarterly |
| | Max N. Kiessolo | Alioune | Strengthening management in workplace | Report of activities, mapping interventions and stakeholders | Meetings, exchange of information | Comprehensive care of HIV in the workplace | Monthly, quarterly |
| | | Elysé | Strengthen managerial capacity of private sector organizations | Report of activities, mapping interventions and stakeholders | Meetings, exchange of information | Managerial capacity of private sector organizations strengthened | Monthly, quarterly |
| Phones Companies | | Salva | Dissemination of information on HIV/AIDS | Areas of coverage, method of collaboration | Meetings, exchange of information | Messages on HIV/AIDS disseminated | Monthly, quarterly |
| Breweries | | Voulu/Salva/Alioune | Enhance prevention in the workplace | Progress report, number of providers trained, needs for capacity and amenities | Meetings, exchanging information, M&E | Implementation of prevention activities in structure | Monthly, quarterly |
| | | Alioune | Strengthen management in workplace | Progress report, number of providers trained, needs for capacity and amenities | Meetings, exchanging information, M&E | Implementation of activities supported in structure | Monthly and quarterly |

| | | | | | | | |
|-----------------------------|--|-------------|---|--|---------------------------------------|---|-----------------------|
| | | Elysé | Strengthen managerial capacity of private sector organizations | | | Improved coordination of control activities in structure | Monthly and quarterly |
| CCLD | | Voulu | Enhancing prevention in workplace | Progress report, number of providers trained, needs for capacity and amenities | Meetings, exchanging information, M&E | Implementation of prevention activities in structure | Monthly and quarterly |
| | | Alioune | Strengthening management in workplace | | | Implementation of activities supported in structure | Monthly and quarterly |
| | | Elysée | Strengthen managerial capacity of private sector organizations | | | Better coordination of control activities in the structure | Monthly and quarterly |
| | | Jhon | Improve PMTCT services and pediatric care of OVC | | | Implementation activities PMTCT and pediatric care in structure | Monthly and quarterly |
| Radio and Television | | Salva | Facilitating community awareness, disseminating messages, broadcasts, commercials | Coverage, grid emission modality of collaboration | Meetings, exchange of information | Messages on HIV/AIDS disseminated | Monthly and quarterly |
| Hotels | | Salva/Voulu | Strengthening prevention | Need for capacity building and amenities | Meetings, exchange of information | | |
| | | Salva/Voulu | Strengthening prevention | Need for capacity building and amenities | | | |
| | | Alioune | Product promotion and OVC | Requirements, method of collaboration | | | |

Annex C. Year 2 expatriate short-term technical assistance

Intermediate Result 1: HCT and prevention services expanded and improved in target areas

| Title | SOW | # of consultants | Approximate timing | Level of effort |
|--|---|------------------|--|--|
| Champion Community specialist | <ol style="list-style-type: none"> 1. Training of implementing partners in the approach 2. Follow-up trainings and support on implementation issues | 1 | <ol style="list-style-type: none"> 1. December 2. June | <ol style="list-style-type: none"> 1. 3.5 weeks 2. 2 weeks |
| HCT quality improvement specialist | <ul style="list-style-type: none"> • Recommend systems for quality improvement at HCT sites (may be combined with PMTCT QA assignment if possible) | 1 | January/ February | 2.5 weeks |
| PMTCT assessment & continuum of care recommendations | <ul style="list-style-type: none"> • Assess the state of PMTCT in DRC • Provide recommendations on two continuum of care issues; identification of HIV exposed infants and children, and linking them into care and treatment facilities | 1 | November 2010 (originally planned/ approved for Year 1) | 26 days |
| Quality improvement training & technical assistance | <ul style="list-style-type: none"> • Quality improvement training for program staff, PNLs, and partners • Establish a ProVIC PMTCT quality improvement plan. • Integration of Q1 activities into the day-to-day work of ProVIC PMTCT sites • On-site mentoring of ProVIC prevention staff for conducting Q1 assessments | 2 | Q3 | 24 days total (8 days in-country X2 +3 days prep X2 + 1 day follow-up X2) |

Intermediate result 2: Care, support, and treatment for PLWHA and OVCs improved in target areas

| Title | SOW | # of Consultants | Approximate Timing | LOE |
|--|--|------------------|--------------------|---------|
| Child protection specialist (OVC) | <ul style="list-style-type: none"> • Provision of focused technical support to develop child protection framework for use with OVCs | 1 | January 2010 | 14 days |
| Resource/ service audit specialist (OVC) | <ul style="list-style-type: none"> • Development of an OVC - appropriate good practice audit tool (including links to PEPFAR child status index tool) • Development of tool and training materials • Roll-out of tool in one pilot area | 1 | January 2010 | 21 days |
| Resource/ service audit specialist (PLWHA) | <ul style="list-style-type: none"> • Development of an appropriate good practice audit tool for PLHA • Development of tool training materials for use by self help groups, implementing NGOs etc • Roll-out of tool in one pilot area • Work with OVC tool specialist to ensure coordination between the models | 1 | December 2010 | 21 days |
| Referrals specialist | <ul style="list-style-type: none"> • Provide technical support to further developing integrated referral systems • Focus on efficiency of referral and counter referral between self help groups, clinical services, NGO services etc. • Link with work from the HSS component on systems strengthening and provincial government support | 1 | May 2011 | 21 days |

Intermediate Result 3: Strengthening of health systems supported

| Title | SOW | # of consultants | Approximate timing | LOE |
|-----------------------|--|------------------|--------------------|-----------|
| Capacity building | <ul style="list-style-type: none"> Support MINAS in developing the training materials for OVC implementing partners | 1 | February | 2-3 weeks |
| Health financing | <ul style="list-style-type: none"> Assess the possibility for community based health financing and recommend potential options that could integrate with Champion Communities | 1 | August | 3 weeks |
| NGO capacity building | <ul style="list-style-type: none"> Review implementation record with ProVIC partner NGOs to date and design training for building capacity in areas identified | 1 | June | 2-3 weeks |

Cross-cutting technical support

| Title | SOW | # of consultants per trip | Approximate timing | LOE |
|---|---|---------------------------|---|---|
| M&E specialist (PATH) | <ul style="list-style-type: none"> M&E support to project, including setting up data collection systems and ensuring quality data collection and reporting for PEPFAR and project PMEPE | 1 | <ol style="list-style-type: none"> January April September | <ol style="list-style-type: none"> 1-2 weeks 2-3 weeks 2-3 weeks |
| Logistics and procurement specialist (PATH) | <ul style="list-style-type: none"> Develop logistics and procurement supply chain management plan/ distribution system for pharmaceuticals (ARVs, test kits, and cotri) as well as PLWHA and OVC packages Backstopping on acquiring commodities and distribution system | 1 | December/ January | 1-3 weeks |

General management, STTA, and home office support

| Title | SOW | # of consultants per trip | Approximate timing | LOE |
|--|--|----------------------------------|--|--|
| Senior program manager (PATH) | <ol style="list-style-type: none"> 1. Project supervision and oversight, mid-year review 2. Work planning for Year 3 | 1 | <ol style="list-style-type: none"> 1. March 2. September | <ol style="list-style-type: none"> 1. 2 weeks 2. 2 weeks |
| Project director (Chemonics) | <ol style="list-style-type: none"> 1. Project supervision and oversight, mid-year review 2. Work planning for Year 3 | 1 | <ol style="list-style-type: none"> 1. March 2. September | <ol style="list-style-type: none"> 1. 2 weeks 2. 2 weeks |
| Field accountant (PATH) | <ul style="list-style-type: none"> • Audit/review of project financial systems | 1 | January | 1 week |
| Grants specialist/project administrator (PATH) | <ul style="list-style-type: none"> • Internal review/audit of project's administrative and operational processes, with emphasis on grants and procurement | 1 | April/May | 1-2 weeks |
| IHAA project supervision | <ul style="list-style-type: none"> • Provide management support to IHAA staff | 1 | February/March | 2 weeks |
| IHAA project supervision | <ul style="list-style-type: none"> • Support Year 3 planning process | 1 | September | 2 weeks |
| EGPAF project supervision | <ul style="list-style-type: none"> • Support Year 3 planning and general project supervision | 1 | September | 7 days |

Annex D. Year 2 budget summary (all partners)

Contract No: GHH-I-00-07-00061-00, Order No. 3
Period Covered: October 1, 2010-September 30, 2011

| Line Item | PATH | Chemonics | IHAA | EGPAF | Total |
|--|---------------------|---------------------|-------------------|-------------------|----------------------|
| I. Salary and wages | \$ 520,210 | \$ 612,433 | \$ 315,589 | \$ 81,323 | \$ 1,529,554 |
| II. Fringe | \$ 155,911 | \$ 410,607 | \$ 78,287 | \$ 37,330 | \$ 682,135 |
| III. Travel and transportation | \$ 50,388 | \$ 181,241 | \$ 116,219 | \$ 16,200 | \$ 364,047 |
| IV. Allowances | \$ 160,874 | \$ 683,620 | \$ 76,924 | \$ 21,890 | \$ 943,308 |
| V. Equipment, Vehicles, and Freight | \$ - | \$ - | \$ - | \$ - | \$ - |
| VI. Special Activities Fund (SAF) | | | | | |
| Procurement | \$ 650,000 | \$ - | \$ - | \$ - | \$ 650,000 |
| Training | \$ - | \$ 685,543 | \$ - | \$ - | \$ 685,543 |
| Grants | \$ 2,400,000 | \$ - | \$ - | \$ - | \$ 2,400,000 |
| Total SAF | \$ 3,050,000 | \$ 685,543 | \$ - | \$ - | \$ 3,735,543 |
| VII. Other direct costs | \$ 42,976 | \$ 751,035 | \$ 4,208 | \$ 5,690 | \$ 803,908 |
| VIII. Indirect costs (Overhead, facilities, G&A) | \$ 621,917 | \$ 810,723 | \$ 116,040 | \$ 19,492 | \$ 1,568,171 |
| IX. Fixed fee | \$ 270,757 | \$ 248,980 | \$ 28,291 | \$ 7,277 | \$ 555,304 |
| Grand total | \$ 4,873,032 | \$ 4,384,181 | \$ 735,557 | \$ 189,201 | \$ 10,181,971 |

DRC INTEGRATED HIV/AIDS PROJECT

YEAR 2 WORK PLAN

October 2010

Contract # GHH-I-00-07-00061-00, Order No 03



USAID
FROM THE AMERICAN PEOPLE

IV.ANNEXES

Annex A: Detailed Year 2 activity plan

IR 1: HCT and prevention services expanded and improved in target areas

Sub-IR 1.2: Community-based and facility-based HCT services enhanced

| Activity | Tasks | Lead/Point Person | Q1 | | | Q2 | | | Q3 | | | Q4 | | | Resources | Milestones |
|--|---|----------------------------------|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-------------------------------------|--|
| | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | | |
| Activity 6: Produce and disseminate HCT and relevant M&E tools | Develop missing tools | HCT Specialist | | | | | | | | | | | | | M&E | |
| | Select suppliers | HCT Specialist | | | | | | | | | | | | | | |
| | Produce tools | HCT Specialist | | | | | | | | | | | | | M&E | |
| | Distribute the tools in all the supported structures | HCT Specialist | | | | | | | | | | | | | M&E | |
| Activity 7: Organize the referral and counter-referral system | With PNLs and PNMLS (national et Provincial), evaluate the referral and counter referral system in our intervention sites | HCT Specialist | | | | | | | | | | | | | PNLS, PNMLS | Mapping of existing partners in each province |
| | Do an inventory of existing documents on referrals and counter-referrals | HCT Specialist | | | | | | | | | | | | | | |
| | Update the mapping of service providers and ongoing activities in Program's intervention sites | HCT Specialist, PMTCT Specialist | | | | | | | | | | | | | Regional Prevention Specialists | |
| | Organize provincial workshops to adopt various reference documents | HCT Specialist | | | | | | | | | | | | | PNLS, PNMLS | |
| | Produce and disseminate referral and counter-referral documents | HCT Specialist | | | | | | | | | | | | | Regional Prevention Specialists | |
| | Organize meetings with partners to assess the functioning of the system | HCT Specialist | | | | | | | | | | | | | PNLS, PNMLS | |
| Activity 8: Ensure the quality of HCT services in testing sites | Put in place a system to control the quality of tests (internal and external) | HCT Specialist | | | | | | | | | | | | | STTA | |
| | Reinforce the capacity of service providers in high quality testing | HCT Specialist, HSS Specialist | | | | | | | | | | | | | | |
| | Evaluate the performance of advisers in the different HCT centers supported by ProVIC | HCT Specialist | | | | | | | | | | | | | PNLS, PNMLS , implementing partners | |
| Activity 9: Continue ensuring effective mechanisms for management of medical waste (DBM) in HCT centers | Arrange advocacy sessions with political and administrative leaders in the provinces on the management of bio-medical waste | HCT Specialist | | | | | | | | | | | | | Regional Prevention Specialists | Environmental compliance ensured in facilities supported by ProVIC |
| | Reinforce the capacity of service providers to manage bio-medical waste | HCT Specialist, HSS Specialist | | | | | | | | | | | | | | |
| | Prepare protocols for collaboration the in management of bio-medical waste in HCT centers | HCT Specialist | | | | | | | | | | | | | | |
| | Assess the functioning of incinerators for health facilities working with ProVIC | HCT Specialist | | | | | | | | | | | | | | |
| | Rehabilitate selected incinerators | HCT Specialist | | | | | | | | | | | | | | |
| | Conduct supervision and technical follow up | HCT Specialist | | | | | | | | | | | | | | |
| Activity 10: Coordinate prevention and HCT activities with partners | Plan prevention campaigns with PSI in different program sites | HCT Specialist | | | | | | | | | | | | | Community Mobilization Specialist | |
| | Support the coordination of MARPs activities in the Matonge and Victoire HCT centers in Kinshasa | HCT Specialist | | | | | | | | | | | | | PNLS | |
| | Support PNLS in the preparation of PICT (DCIP) tools | HCT Specialist | | | | | | | | | | | | | PNLS | |
| | Support the implementation of Counseling and Testing strategies for couples | HCT Specialist | | | | | | | | | | | | | STTA | |
| | Organize joint supervisions to HCT centers with PNLS | HCT Specialist | | | | | | | | | | | | | Health Zone teams | |

IR 2: Care, support and treatment for PLWHA and OVC improved in target areas

Sub-IR 2.2: Care and support to orphans and vulnerable children (OVC) improved in the targeted areas

| Activity | Tasks | Lead/Point Person | Q1 | | | Q2 | | | Q3 | | | Q4 | | | Resources | Milestones |
|---|---|-----------------------------|-----|-----|-----|-----|-----|-----|-----|-----|-----|------|-----|---|--|------------|
| | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | July | Aug | Sep | | |
| Activity 1 : Ensure that PLWHA mobilization engages PLWHA on, and supports OVC in, ensuring the welfare and wellbeing of their children | Within national and provincial project approaches workshops ensure that grantees have planned specific activities for OVC in their work plan including OVCs in public orphanages, in families and in the streets | Care and Support Specialist | | | | | | | | | | | | HSS Specialist, and Community Mobilization Specialist Home-Based Care specialist | | |
| | Monitor and document OVCs activities in grantees work plan | | | | | | | | | | | | | | | |
| Activity 2 : Reinforce the capacity of grantees, Champion Communities, teachers and tutors to work with OVC through "child to child" methodology | Design the workshop and elaborate the agenda | Care and Support Specialist | | | | | | | | | | | | | One national workshop held on child to child approach | |
| | Elaborate the facilitation notes | | | | | | | | | | | | | | | |
| | Define the roles and responsibilities | | | | | | | | | | | | | | | |
| | Prepare the materials | | | | | | | | | | | | | | | |
| | Facilitate and document the TOT workshop | | | | | | | | | | | | | | | |
| | Help trainees to plan TOP at provincial level | | | | | | | | | | | | | | | |
| | Supervise TOP at provincial level | | | | | | | | | | | | | | | |
| Support implementing partners to plan self-help groups with PLWHA | | | | | | | | | | | | | | | | |
| Activity 3 : Organize groups discussion with OVC peer educators on child to child approach | Supportive supervision to ensure quality during child to child discussions on several themes "health and nutrition, education, OVC placed in host shelter economic strengthening, psychosocial support, education, social inclusion, negotiation of difficult situations with adults, adults rapes, violence and child protection, child well being, etc) | Care and Support Specialist | | | | | | | | | | | | Implementing partners Home-Based Care specialist Care and support specialists | | |
| Activity 4 : Provide educational and vocational support to OVC | Provide educational support through nutrition, schools fees and kits based on targeting criteria | Care and Support Specialist | | | | | | | | | | | | Home-Based Care specialist Regional Care specialists | 1000 OVC received vocational and professional training | |
| | Use IHAA building blocks manual to working with children (through child to child), families (through the positive living mobilization), communities (through Champion Communities) and schools, to find more sustainable solutions at both access and quality of education | | | | | | | | | | | | | Grantees Champion community spcialist Champion community steering committee | | |
| | Organize coordination meeting with Global Fund, UNICEF, FAO, World Vision, and the World Bank to discuss sustainability, leverage resources and cost sharing mechanism in care and supporto adress OVCs matters together | | | | | | | | | | | | | COP, DCOP | | |
| | Supportive supervision to ensure quality | | | | | | | | | | | | | Home-Based Care specialist Regional Care specialists | | |
| | Document success stories | | | | | | | | | | | | | Grantees | | |
| Activity 5 : Provide nutritional support to malnourished OVC | Support grantees to identify and provide nutritional and appropriate food to 2201 malnourished OVCs | Care and Support Specialist | | | | | | | | | | | | Home based care Specialist Grantees | | |
| | Elaborate and disseminate in OVCs families a booklet that provide guidance about local nutritional and energetic food and encourage their production and consumption | | | | | | | | | | | | | Home Based Care Specialist, Implementing Partners, Regional Care and Support Specialists, Peers educators Champion Communities | | |
| | Ensure that the nutritional status of OVC is monitored and design appropriate responses based on identified needs. | | | | | | | | | | | | | Grantees, Champion Communities, M&E | | |

IR 2: Care, support and treatment for PLWHA and OVC improved in target areas

Sub-IR 2.2: Care and support to orphans and vulnerable children (OVC) improved in the targeted areas

| Activity | Tasks | Lead/Point Person | Q1 | | | Q2 | | | Q3 | | | Q4 | | | Resources | Milestones |
|---|--|-----------------------------|-----|-----|-----|-----|-----|-----|-----|-----|-----|------|-----|---|---|--|
| | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | July | Aug | Sep | | |
| Activity 6 : Provide medical or clinical support to OVC | Adapt the "health journey model of IHAA" to reinforce the capacity of grantees to organize the health care referral of OVCs | Care and Support Specialist | | | | | | | | | | | | Grantees, HSS PLHA auto-support groups | | |
| | Develop targeting criteria for OVCs selection, and a system for administering the payments with clear accountability to communities | | | | | | | | | | | | | Grantees, HSS PLHA auto-support groups | | |
| | Provide to 2201 OVCs with a health or clinical care referral | | | | | | | | | | | | | | | Grantees, HSS PLHA auto-support groups |
| | Ensure that grantees have planned medical and clinical care activities in their budget and will establish an agreement with existing service providers to give care and treatment to concerned OVC | | | | | | | | | | | | | | | Grantees, HSS PLHA auto-support groups |
| | Ensure discussion within Champion Communities to set up sustainable mechanism for this kind of support in future years | | | | | | | | | | | | | | | Grantees, HSS PLHA auto-support groups |
| | Document success stories | | | | | | | | | | | | | | | Grantees, HSS PLHA auto-support groups |
| Activity 7 : Provide financial support to OVC's income generating activities | Provide vocational and professional training to 1000 OVCs | Care and Support Specialist | | | | | | | | | | | | Grantees | 200 OVC supported with income generating activities | |
| | Train 200 OVCs in trade for a period not exceeding 10 months | | | | | | | | | | | | | Grantees | | |
| | Create and negotiate micro finance opportunities within Champion Community including attractive loan for revolving fund, and training of beneficiaries on micro finance management | | | | | | | | | | | | | | | Mutombo Foundation Opportunities International COP, DCOP |
| | Provide OVCs with seed funding to launch their own income generating activities | | | | | | | | | | | | | | | |
| | Ensure supportive supervision | | | | | | | | | | | | | | | Regional Care and Support Specialists |
| | Organize a micro finance workshop in each province | | | | | | | | | | | | | | | Regional Care and Support Specialists |
| | Document impact and success stories in supporting OVCs IGA | | | | | | | | | | | | | | | Grantees Regional Care and Support Specialists |
| | | | | | | | | | | | | | | | | |
| Activity 8 : Organize advocacy campaigns in each Champion Community to promote community engagement, solidarity and support toward OVC | Define the terms of reference | Care and Support Specialist | | | | | | | | | | | | Regional Care and Support specialists Grantees and different Steering committees of the Champion Communities. | One advocacy campaign organized in each Champion Community | |
| | Help Regional Care to organize and supervise the advocacy campaigns at provincial level around 1) vulnerability, 2) social role and responsibility of community toward OVC, 3) mechanisms for promoting and ensuring community solidarity toward OVC, 4) existing and potential opportunities for care and support to OVC and others | | | | | | | | | | | | | Regional Care and Support specialists Grantees and different Steering committees of the Champion Communities | | |
| | Organise meeting and one to one visit to seek the participation of key stakeholders concerned with OVC issues and promoting child wellbeing | | | | | | | | | | | | | | | UNICEF, MINAS, Ministry of Gender and Family, Global Fund, PNMLS, Foundation M/Zee Kabila, Save the Children and other partners and stakeholders |
| | Document impact and success stories of the advocacy campaigns | | | | | | | | | | | | | | | Regional Care and Support Specialists Grantees and different |
| Activity 9: Ensure social and legal protection for OVC | Promote and disseminate among key stakeholders in all ProVIC sites 4000 copies of the Child Status index | Care and Support Specialist | | | | | | | | | | | | Regional Care and Support Specialists Community Mobilization Specialist | | |
| | Insure provision of focussed technical support to develop child protection framework for use with OVCs | Care and Support Specialist | | | | | | | | | | | | International STTA Child Protection Specialist - OVC | | |
| | Development of tool training materials | Care and Support Specialist | | | | | | | | | | | | International STTA | | |
| | Roll out of tool in one pilot area | Care and Support Specialist | | | | | | | | | | | | International STTA Resource/service audit Specialist – OVC | | |
| Activity 10: Undertake good practice audit of care, support and protection services for OVC | Develop methodology and test in 3 communities | Care and Support Specialist | | | | | | | | | | | | International STTA | 11005 OVC targetted across all project implementation sites | |
| | Apply methodology in all implementation areas | Care and Support Specialist | | | | | | | | | | | | Regional Care and Support Specialists | | |
| | Disseminate results amongst partners and develop plans for responses to poor practice | Care and Support Specialist | | | | | | | | | | | | Regional Care and Support Specialists | | |

IR 3: Strengthening of health systems supported

Sub-IR 3.3: Strategic information systems at community and facility levels strengthened

| Activity | Tasks | Lead/Point Person | Q1 | | | Q2 | | | Q3 | | | Q4 | | | Resources | Milestones |
|---|---|----------------------------------|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|--|---|------------|
| | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | | |
| Activity 1: Strengthen ProVIC monitoring and evaluation (M&E) system | Develop regional quarterly operation plans, including monitoring activities | ProVIC M&E team | | | | | | | | | | | | M&E (DC) | ProVIC M&E system is organized to ensure high-quality data | |
| | Implement monitoring activities per planning | ProVIC M&E team | | | | | | | | | | | | M&E (DC) | | |
| | Provide hands-on training/support on routine data quality assurance (RDQA) to M&E team | M&E (DC) | | | | | | | | | | | | M&E (DC): short-term technical assistance (STTA) | | |
| | Work with M&E team on Year 3 Work Plan | M&E (DC) | | | | | | | | | | | | M&E (DC): STTA | | |
| Activity 2: Make data collection tools available to implementing partners | Harmonize data collection tools to reflect national data needs | ProVIC M&E team | | | | | | | | | | | | M&E (DC) | Harmonized data collection tools are available to implementing partners | |
| | Finalize data collection tools [HIV counseling & testing (HCT), prevention of mother-to-child transmission (PMTCT), | ProVIC M&E team | | | | | | | | | | | | M&E (DC) | | |
| | Identify M&E counterparts/focal points for new implementing partners | ProVIC M&E team | | | | | | | | | | | | M&E (DC) | | |
| | Organize a briefing for new partners on the ProVIC reporting system I | ProVIC M&E team | | | | | | | | | | | | M&E (DC) | | |
| | Ensure integration of HIV program collection tools into project partners' reporting systems (e.g., family planning, gender, etc.) | ProVIC M&E team | | | | | | | | | | | | M&E (DC) | | |
| Activity 3: Improve implementing partners' M & E capacity | Develop training materials for local actors: ProVIC M&E tools, indicators, guidelines, self-evaluation tools etc. | M&E (DC), ProVIC team | | | | | | | | | | | | M&E (DC) | Implementing partners are trained in ProVIC M&E tools and systems | |
| | Organize trainings of trainers (TOTs) | ProVIC M&E team, HSS Coordinator | | | | | | | | | | | | M&E (DC) | | |
| | Conduct M&E trainings | M&E (DC), ProVIC M&E team | | | | | | | | | | | | M&E (DC): STTA | | |
| Activity 4: Strengthen quality assurance system | Develop/adapt RDQA tools for ProVIC | M&E (DC) | | | | | | | | | | | | M&E (DC) | Improved quality of information reported | |
| | Integrate RDQA into monitoring visits | ProVIC M&E team | | | | | | | | | | | | M&E (DC) | | |
| | Conduct internal audits | M&E (DC), M&E (Kinshasa) | | | | | | | | | | | | M&E (DC): STTA | | |

IR 3: Strengthening of health systems supported

Sub-IR 3.3: Strategic information systems at community and facility levels strengthened

| Activity | Tasks | Lead/Point Person | Q1 | | | Q2 | | | Q3 | | | Q4 | | | Resources | Milestones |
|---|--|------------------------------------|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|----------------|--|
| | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | | |
| Activity 5: Support M&E reporting systems | Participate in national and/or regional M&E task force meetings | ProVIC M&E team | | | | | | | | | | | | | M&E (DC) | Improved reporting systems |
| | Design a database aligning ProVIC indicators with national data processing system (CRIS) | M&E (Kinshasa) | | | | | | | | | | | | | STTA | |
| | Train ProVIC M&E team in data processing software | M&E (Kinshasa) | | | | | | | | | | | | | STTA | |
| Activity 6: Support M&E system in Champion Communities (CCs) | Provide inputs into community assessment methodology and tools | M&E (DC), CC Coordinator | | | | | | | | | | | | | M&E (DC) | CCs are able to identify community challenges/issues and solutions |
| | Adapt monitoring tools for CC approach | M&E (DC, Kinshasa), CC Coordinator | | | | | | | | | | | | | M&E (DC) | |
| | Organize joint supervision in CCs | M&E (DC, Kinshasa), CC Coordinator | | | | | | | | | | | | | M&E (DC): STTA | |
| | Support final evaluation of CC approach | M&E (DC, Kinshasa), CC Coordinator | | | | | | | | | | | | | M&E (DC): STTA | |
| Activity 7: Provide support for M&E activities at the national and provincial levels to National AIDS Control Program (PNLS), National Multisectoral AIDS Program (PNMLS), Ministry of Social Affairs (MINAS) | Support PNMLS in operational and sectoral planning | ProVIC M&E team | | | | | | | | | | | | | M&E (DC) | National and provincial M&E systems operate more efficiently and effectively |
| | Support MINAS in piloting its orphans and vulnerable children (OVC) tools in 2 provinces | M&E (Kinshasa) | | | | | | | | | | | | | M&E (DC) | |
| | Joint monitoring missions with MINAS | M&E (DC, Kinshasa) | | | | | | | | | | | | | M&E (DC): STTA | |
| | Support MINAS' establishment of OVC database | M&E (Kinshasa) | | | | | | | | | | | | | M&E (DC) | |
| | Support MINAS M&E system through implementation of OVC M&E plan | ProVIC M&E team | | | | | | | | | | | | | M&E (DC) | |
| | Support PNLS in designing tools according to new norms (PMTCT, HCT) | ProVIC M&E team | | | | | | | | | | | | | M&E (DC) | |