

DRC INTEGRATED HIV/AIDS PROJECT

PROJET INTEGRE DE VIH/SIDA AU CONGO (PROVIC) YEAR 3 ANNUAL REPORT

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ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ART	antiretroviral therapy
ARV	antiretroviral medication
AZT	zidovudine
BCC	behavior change communication
C2C	child-to-child
CAD	<i>Club des Amis Damien</i>
C-Change	Communication for Change
CDC	US Centers for Disease Control and Prevention
CH	<i>Centre Hospitalier</i>
CIELS	<i>Comité Inter-Entreprise de Lutte contre le Sida</i>
COP	Chief of Party
CS	<i>Centre de santé</i>
CSN	<i>Centre Solidarité Nationale</i>
CSW	commercial sex worker
CTX	cotrimoxazole
DCIP	<i>Dépistage Conseil Initié par le Prestataire</i>
DCOP	Deputy Chief of Party
DISPE	<i>Direction Interventions Spécifiques pour la Protection des Enfants</i>
DQA	data quality assessment
DRC	Democratic Republic of Congo
ECZS	<i>Equipe Cadre de la Zone de Santé</i>
EGPAF	Elizabeth Glaser Pediatric AIDS Foundation
EID	early infant diagnosis
FACT	Field accounting and compliance team
FANTA	Food and Nutrition Technical Assistance
FAO	Food and Agriculture Organization of the United Nations
FHI	Family Health International
FY	Fiscal Year
GBV	gender-based violence
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
HCT	HIV counseling and testing
HGR	<i>Hôpital Général de Référence</i>
HIV	human immunodeficiency virus
HSS	health systems strengthening
IGA	income-generating activity
IHAA	International HIV/AIDS Alliance
IPC	<i>Initiative Privée Communautaire de lutte contre le VIH</i>
IR	Intermediate Result
LCD	Local Capacity Development
LGBTI	lesbian, gay, bisexual, transgender, and intersex
LIFT	Livelihood and Food Security Technical Assistance
M&E	monitoring and evaluation
MARP	most at-risk population
MINAS	<i>Ministère des Affaires Sociales</i>
MOH	Ministry of Health
MOU	memorandum of understanding
MSH	Management Sciences for Health

MSM	men who have sex with men
NGO	nongovernmental organization
OCA	organizational capacity assessment
OVC	orphans and vulnerable children
PATH	Program for Appropriate Technology in Health
PCR	polymerase chain reaction
PEPFAR	US President's Emergency Plan for AIDS Relief
PHDP	Positive Health, Dignity and Prevention
PICT	provider-initiated counseling and testing
PLWHA	people living with HIV/AIDS
PMTCT	prevention of mother-to-child transmission of HIV
PNLS	<i>Programme National de Lutte Contre le VIH/SIDA</i>
PNLT	<i>Programme National de Lutte contre la Tuberculose</i>
PNMLS	<i>Programme National Multisectoriel de Lutte Contre le VIH/SIDA</i>
PNSA	<i>National pour la Sécurité Alimentaire</i>
PNSR	<i>Programme National de Santé de la Reproduction</i>
PRONANUT	<i>Programme National Intégré d'Alimentation et de Nutrition</i>
PROSANI	<i>Projet de Santé Intégré</i>
ProVIC	<i>Projet Intégré de VIH/SIDA au Congo</i>
PSI	Population Services International
PSSP	<i>Progrès Santé Sans Prix</i>
RDQA	routine data quality assurance
RIG	Regional Inspector General (USAID)
RNOAC	<i>Réseau National d'Organisations Assises Communautaire</i>
SCMS	Supply Chain Management System
SGBV	sexual and gender-based violence
STI	sexually transmitted infection
TAPAP	Technical Assistance Prioritization Action Plan
TB	tuberculosis
TOP	training of providers
TOT	training of trainers
TWG	Technical Working Group
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNTA	Mobile Nutritional Treatment Unit
UNTI	Nutritional Intensive Treatment Unit
USAID	US Agency for International Development
VCT	voluntary HIV counseling and testing
VSLA	village savings and loan association
WHO	World Health Organization
ZS	<i>Zone de santé</i>

EXECUTIVE SUMMARY

Projet Intégré de VIH/SIDA au Congo (ProVIC) is pleased to present its Year 3 annual report, covering the period October 2011 through September 2012. ProVIC's mission in the Democratic Republic of Congo (DRC) is to contribute to the reduction in the incidence and prevalence of HIV and mitigate its impact on people living with HIV/AIDS (PLWHA) and their families in the five provinces where ProVIC operates (Bas-Congo, Katanga, Kinshasa, Orientale, and Sud Kivu). Underlying this stated purpose is a deeper vision of sustainability and engagement, which constitutes the core strategy and driving force of ProVIC: through the creation of “champion communities” with linkages and access to high-quality, integrated HIV/AIDS services, Congolese citizens can take control of their response to the AIDS epidemic.

Now finishing its third year, ProVIC continues to be a leader in HIV/AIDS service provision in DRC, including HIV counseling and testing (HCT), prevention of mother-to-child transmission of HIV (PMTCT), and community-based care and support. Importantly, ProVIC has been able to implement innovation in both community and clinical approaches to HIV services, all within the context of national strategies and norms, and the dynamic challenges associated with operations in the country. One of ProVIC's heralded innovations—nighttime mobile HCT to reach the stigmatized high-risk population of men who have sex with men (MSM) with critical services—was identified as a promising practice at the International AIDS Conference in July 2012. The US President's Emergency Plan for AIDS Relief (PEPFAR) AIDSTAR-One project identified ProVIC's champion communities as a promising community mobilization model and sent a representative to visit champion communities in Bas-Congo and Kinshasa to develop and publish a case study. The Champion Community model is demonstrating that community mobilization can awaken and transform communities in DRC to the interest of many, including national and local government leaders.

As ProVIC acts as a catalyst for greater community involvement in the response to HIV/AIDS, ProVIC's technical assistance services are also expanding to meet a growing demand for increased access to key HIV services. In Year 3, ProVIC's activities across five provinces, 27 health zones, and 44 champion communities continued to grow in quality, scope, and scale. In particular, ProVIC's commitment to strengthen health systems and government leadership continued to grow. Project support to 22 government health structures expanded to 41 health facilities by the tail end of the fiscal year. Mobilized champion communities now have access to a wider range of improved public-sector health facilities.

Through ProVIC's **PMTCT program**, 32,801 pregnant women received counseling and testing (up from 28,336 in Fiscal Year [FY] 2012). Of these, 569 were placed on antiretroviral prophylaxis. ProVIC's early infant diagnosis services ensured that 381 children were tested for HIV in the first 12 months of life, in spite of the massive logistical challenges in the transport of samples across DRC to Kinshasa, where the country's only polymerase chain reaction testing laboratory operates.

ProVIC's 44 champion communities have ignited and sustained a whirlwind of activity around the theme of HIV/AIDS, including ongoing localized prevention and awareness-raising campaigns, often conducted door to door by ProVIC-trained volunteers. In Year 3,

through ProVIC's **HIV prevention program**, 443,692 individuals were reached with sex behavior change messages to reduce their risk of HIV infection. These targeted prevention activities led to the uptake of HCT services by thousands of people who are part of most at-risk populations (MARPs). For example, prevention messages to 20,363 truck drivers resulted in 11,102 being tested (55 percent), while prevention messages to 11,385 commercial sex workers (CSWs) resulted in 7,206 being tested (63 percent).

ProVIC's **HCT program** operates through health facilities, community testing centers, and mobile clinics with the goal of using limited commodity resources for maximum impact. After targeted outreach to MARPs (especially CSWs and MSM), 143,075 individuals were tested via ProVIC services. Of these, 5,822 individuals tested HIV positive, which represents an overall prevalence rate of 4 percent, as compared to an estimated national prevalence rate of 3 percent. This suggests that the ProVIC services were successful in better reaching often hidden at-risk populations. In response to the increasing feminization of the HIV epidemic in DRC, 56 percent of individuals tested were women. ProVIC has now fully transitioned to finger-prick blood draw technology, which lowers costs and improves efficiency at the testing sites.

ProVIC's vision of holistic HIV/AIDS care and support includes the establishment of community-driven structures linked to health facilities and champion communities. Individuals testing or known HIV positive are referred to ProVIC's community-based **care and support services**. These services are grounded in three interlinked core activities: PLWHA self-help groups, child-to-child psychosocial support groups, and home visits. Nearly two hundred self-help groups have been organized to offer psychosocial support, referral to clinical HIV services, tuberculosis (TB) screening and referrals, nutritional counseling, and other services. These groups also play an important part in improving linkages to health facilities, particularly when the groups conduct their meetings at local health facilities.

To improve the quality and tracking of beneficiaries, ProVIC has transitioned to an individual patient record system for all PLWHA and orphans and vulnerable children (OVC). This allows for better tracking of patient progress as well as significantly lowering the risk of double-counting results. To date, 7,261 PLWHA have received community- or clinic-based services supported by ProVIC within this fiscal year. Of those, 4,780 received clinical HIV services in their local hospital, and 397 individuals (adults and children) were placed on TB treatment in hospitals supported by ProVIC. (ProVIC is not yet able to track those who start TB treatment outside of ProVIC-supported sites.) In addition, 8,299 OVC were supported by ProVIC, including 1,946 children who received clinical services and 1,542 who were supported with school fees and materials. Of those served via ProVIC-supported Care and Support activities, 61 percent were women and girls. To encourage household economic strengthening, ProVIC supported 741 income-generating activities of varying size and intervention types, including poultry farms, community agriculture and livestock, milling, small bakeries, and community savings and loans.

ProVIC also focuses on health systems strengthening at the national level and within the provinces and health zones where it operates. For example, at the national policy level, ProVIC provided consistent technical support to the national PMTCT task force and led the process to finalize the national protocol for nutritional care of PLWHA, as well as the HIV/AIDS palliative care guide. These protocols and guides will be used by health providers across DRC to ensure standards are being met for the nutritional support of PLWHA.

Critical to the delivery of these varied services are clear and well-functioning referral and counter-referral systems. To support this, in coordination with local government, ProVIC has developed referral directories and tools for the four main urban areas in which ProVIC works, and has begun a process of consultation and information-sharing to create vibrant linkages and networks of support.

ProVIC has supported its local nongovernmental organization (NGO) partners with their institutional capacity-building, particularly with US Agency for International Development (USAID) compliance and accounting/financial systems. For example, ProVIC has improved the accounting systems used by partner NGOs by training accountants and installing QuickBooks on newly procured computers.

Other important accomplishments during this fiscal year include the establishment of an office in Kisangani in Province Orientale, and, as mentioned above, the development of an online database which allows ProVIC to gather and share high-quality data across its many partners and services. This database will enable ProVIC to conduct program analyses more quickly and reorient program activities on the ground, as needed. For example, the database enables the team to identify the sociodemographic characteristics (e.g., occupations) of individuals with especially high prevalence rates. This information is suggestive due to small sample sizes, but it will still enable a more specific focus for activities in the future.

While the accomplishments of ProVIC can be viewed from an aggregated and national perspective, it is equally important to examine ProVIC's work from a provincial perspective. The DRC's vast geographic coverage and economic and cultural diversity suggest that difference provinces have different dynamics that lead to more or less HIV risk and require different levels and types of responses. ProVIC takes into account these different profiles and needs with both champion communities and related health services.

For example, the epidemic is more generalized in the province of Katanga, which has DRC's highest prevalence rate, according to *Programme National de Lutte Contre le VIH/SIDA*, and a prevalence rate of 8.6 percent in ProVIC sites. It also has linkages to the southern African epidemic. For this province, services are offered as widely as possible through a mix of community and health facilities. On the other hand, Kinshasa has a mixed-generalized epidemic and a lower prevalence rate of 3 percent, so ProVIC targets high-risk populations such as CSWs and MSM to ensure a cost-effective use of project resources.

A closer look at ProVIC's provincial strategies shows a marked impact. Katanga is characterized by its industrial and artisanal mining and trucking operations, which link to the AIDS epidemic in southern Africa. ProVIC's work is focused on the provincial capital of Lubumbashi and the copperbelt trucking route from Kolwezi to the border town in Kasumbalesa. ProVIC partners work intensively with truck drivers, CSWs, and bar owners along the DRC-Zambia border, where copper-carrying trucks often wait weeks to cross the border en route to South Africa. In response to the rising HIV rate, ProVIC has been shifting its resources toward Katanga by partnering with an additional ten new hospitals, including Sendwe Provincial Hospital, the largest hospital in Katanga Province. In FY12, Katanga sites tested 33,341 individuals at six hospitals and health centers, including 5,268 women within the PMTCT program, while 4,424 PLWHA/OVC received at least one care service.

The province of Kinshasa is dominated by the bustling capital city of Kinshasa, with its dense urban population of 12 million inhabitants. ProVIC operates through eight hospitals in

Kinshasa, including three new PMTCT Acceleration sites. In FY12, Kinshasa sites tested 52,979 individuals, including 16,626 women within the PMTCT program. By targeting MARPs, 639 MSM and 3,361 CSWs were reached through ProVIC's innovative nighttime mobile HCT services. In addition, 6,783 PLWHA/OVC received at least one care service.

In the western province of Bas-Congo, ProVIC works along the major transportation axis with truck drivers and CSWs, as well as with the largest health structures in Matadi, DRC's major port town. In FY12, Bas-Congo sites tested 27,607 individuals, including 3,553 women within the PMTCT program, at seven public hospitals and health centers, and 2,137 PLWHA/OVC received at least one care service.

Due to the history of conflict and abuse toward women, in Sud Kivu, ProVIC focuses on NGOs that promote women's empowerment in the provincial capital of Bukavu and in Uvira on Lake Tanganyika. ProVIC supports prevention and counseling and testing of high-risk groups of truck drivers and fishermen. In FY12, Sud Kivu sites tested 28,051 individuals at four hospitals and health centers, including 6,371 women within the PMTCT program, and 2,216 PLWHA/OVC received at least one care service.

With new USAID funding, ProVIC also initiated some much-needed gender-based violence (GBV) prevention and response programming in Year 3. The cities of Kisangani and Kinshasa were identified by USAID as the locations for new strategies and activities to address GBV. Champion communities received sensitization messages while GBV screening and clinical care is being integrated into health structures, including five sites in Kisangani and three additional sites in Kinshasa. To date, 14,922 individuals have been reached with GBV reduction messages in Kinshasa, while activities are just beginning in Kisangani. ProVIC is presently developing a "Champion Men" strategy to ensure greater male participation through strong male anti-GBV role models.

ProVIC opened an office in Kisangani, Province Orientale, in June 2012, after receiving an amendment to the ProVIC contract for expanded activities in April. ProVIC rapidly set out to recruit staff, develop plans with the local government, identify and train partners, and catalyze four new champion communities. By September 2012, for example, ProVIC had initiated PMTCT services in six health structures.

FY12 was not without challenges. First-quarter activities were slowed by a combination of events, including (1) the DRC presidential elections, (2) a delayed USAID approval process for ProVIC's standard and fixed-obligation grants, (3) a delay in plans for the Supply Chain Management System (SCMS) project to take over procurement of commodities, (4) the theft of HIV test kits, and (5) a delay in the planned rollout of PMTCT Acceleration sites.

The DRC presidential elections created restrictions and disturbances in November and December of 2011, which inhibited HCT service and prevention outreach, although hospitals functioned in a routine manner. For example, ProVIC reached 17,900 individuals with prevention messages in the turbulent first quarter, and then averaged 37,700 in the final three quarters. The shocking theft of 50,000 HIV tests was a significant blow to project activities, as was the delayed transition to SCMS-led procurement of commodities, which started roughly four months later than originally anticipated. The absence of these test kits led to an HCT achievement rate of 65 percent. In addition, ProVIC's PMTCT target was originally set with the assumption that 22 new PMTCT Acceleration sites would be rolled out early in Year 3; these did not begin to materialize until September 2012 due to delays associated with

PEPFAR coordination of the PMTCT Acceleration Program (and ProVIC contract amendment finalization). Despite this challenge, ProVIC was able to achieve 65 percent of the target.

In summary, FY12 was a successful year for ProVIC as it continued to support a spectrum of services across a multitude of NGO, health facility, and government partners in the highly dynamic and complex environment of DRC. ProVIC met most of its targets even when factors outside of the project's control were taken into consideration. In areas where ProVIC had difficulty, such as meeting some Care and Support targets (most specifically, TB screening and referrals targets, which were also impacted by sporadic stockouts of supplies and drugs outside of ProVIC's control), ProVIC will apply greater managerial and technical focus in FY13, all the while ensuring increased coordination with the DRC government.

SECTION 1: PROGRESS TOWARD RESULTS

Intermediate Result 1: HIV counseling and testing and prevention services improved in target areas

Overview/Summary

The Champion Community approach has been intensively used in Year 3 to bring 44 communities together to identify HIV-related issues, and plan, implement, and evaluate actions that were aimed at increasing the demand for and utilization of HIV/AIDS-related services. The approach has also helped to establish a strong linkage between communities and health and social structures. The existing 44 champion communities have been strengthened and the approach is being adopted by the government of the Democratic Republic of Congo (DRC) as one effective mechanism to fight HIV at the community level. Innovative approaches, such as “moonlight” HIV counseling and testing (HCT) and the use of mobile testing units, have been optimized to meet the needs of the high-risk and difficult-to-reach populations. In addition, the needs of pregnant women and their infants have been responded to with high-quality, tailored prevention of mother-to-child transmission of HIV (PMTCT) and early infant diagnosis (EID) services under the DRC’s strategic objective of PMTCT Acceleration. Gender-based violence (GBV) activities have also been launched in Kinshasa and Kisangani to provide holistic care and support services to survivors of GBV.

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

Community workers as well as the members of the steering committees in each of the 44 champion communities have been actively involved in sensitization activities aimed at ensuring that each member of the community has access to accurate and factual information about HIV/AIDS and its prevention. Appropriate and contextualized prevention messages and communications materials have been used to reach out to specific groups within the communities and to induce the adoption of responsible sexual behaviors.

In Year 3, a US President’s Emergency Plan for AIDS Relief (PEPFAR) delegation visited our champion communities in Kinshasa and Katanga to study the approach. The visit was an opportunity for *Projet Intégré de VIH/SIDA au Congo* (ProVIC), the US Agency for International Development (USAID)/DRC team, and partners to share results and lessons learned from the model, which serves as a catalyst for implementation of field-based activities. The PEPFAR delegation, comprised of the USAID HIV/AIDS Director, US Centers for Disease Control and Prevention (CDC) HIV/AIDS Director, Office of the US Global AIDS Coordinator Operations Director, and PEPFAR Ambassador Eric Goosby, visited a nighttime mobile unit conducting HIV screening in the Kinkenda Champion Community of Kinshasa. They also visited the *Hôpital Général de Référence* (HGR) Kenya, the Kasumbalesa Champion Community in Katanga Province, and one of our mobile HCT activities in the mining community of Luisha.

Activities and achievements

Activity 1. Strengthen ownership and sustainability by supporting champion communities to consolidate results from Year 2

During the latter part of Year 3, the project implemented recommendations made by ProVIC's consultant LouLou Razaka. These recommendations have helped the project refine its strategy to strengthen the capacity of champion communities toward sustainability. Concrete actions have been framed to ensure the progressive, step-by-step transfer of skills, knowledge, and responsibilities from grantees to communities through steering committees and community workers.

Ms. Razaka visited eight champion communities, four in Kinshasa and four in Bas-Congo. Her recommendations included (1) a reorganization of Champion Community Steering Committee member roles for better management of activities; (2) mobilization of local resources, including human and financial; (3) support and monitoring of community workers to encourage self-sufficiency and personal development; and (4) more focused efforts on working with and coaching youth and teens. She also recommended expanding champion communities from 40,000 to 60,000 people. To support this expansion, the number of community workers in each Champion Community was increased from 30 to 40, for a total of 400 additional workers. The community workers represent various sectors and interests, and were selected based on their willingness to volunteer, credibility within the community, and level of education.

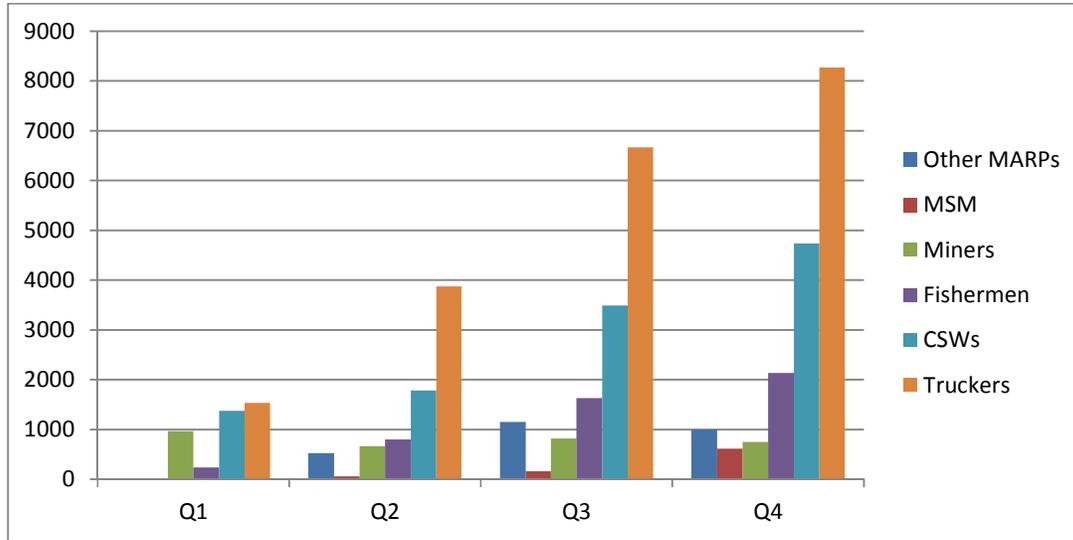
Lessons learned were subsequently applied to Kisangani, where Champion Community members received appropriate training to directly carry out HIV/AIDS-related activities without assistance from an external nongovernmental organization (NGO). Community supervisors have been identified in each Champion Community. They will be trained in data collection, reporting, monitoring, and liaising with the health zones, ProVIC, and other local leaders. In addition, the members of all 44 steering committees, as well as community workers, will be trained in small project design, implementation, monitoring, resource mobilization, advocacy, and communication for behavior change.

A total of 443,692 people in the 44 champion communities were reached with behavior change communication (BCC) messages through peer education and door-to-door campaigns carried out by 1,800 community workers. Of this group, 131,631 people received messages about abstinence.

Of all people reached from October 2011 through September 2012, 43,247 were most at-risk populations (MARPs). Figure 1a looks at which groups were reached with prevention messages in each quarter over the course of the year. The group most reached with sexual prevention messages was truck drivers, while the least reached was men who have sex with men (MSM) (the project only started targeting MSM with sensitization activities in the third quarter). This is because the champion communities of Mvuzi et Kalamu (Bas-Congo), Sakania (Katanga), Mbankana (Kinshasa), and Bagira (Sud Kivu) are comprised of not only border entry points, but also important stops/transit stations for trucks coming from different regions or countries, such as Tanzania and Zambia. The lowest results were recorded among MSM. This group is difficult for community mobilizers to reach because members tend to live in secret and do not wish to self-identify. The peer education approach has been more effective in targeting MSM.

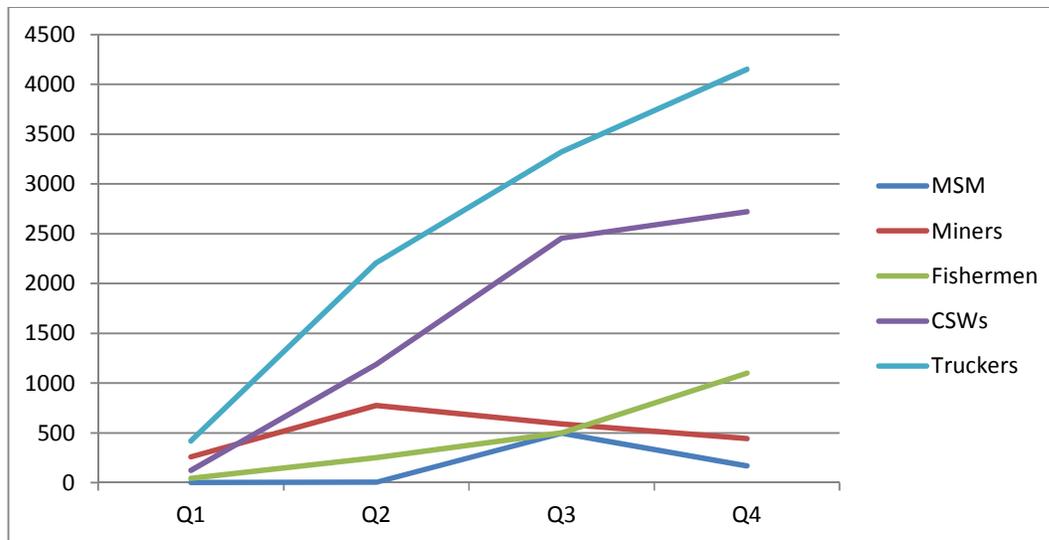
Through observations made by communities, the project determined that other groups should also be considered as persons at risk because of their high-risk behaviors, including sexual partners of truck drivers and petty traders/vendors in quarries and mines.

Figure 1a. Number of MARPs, by type and quarter, reached with prevention messages.



The results illustrated in Figure 1a show a correlation with Figure 1b (below); that is, between those populations that were most accessed with prevention messages and those that most used HIV testing services. Specifically, truck drivers and commercial sex workers (CSWs), who received the most prevention messages, were the most likely to get tested for HIV.

Figure 1b. Increased use of testing services among MARPs sensitized in champion communities.



Monthly reviews and monitoring of activities of each of the 44 champion communities allowed ProVIC to closely monitor the success of activities and progress toward meeting the objectives of each community work plan. A cross-section of each community was actively involved in the monitoring, including health zone staff, community leaders, social workers, group facilitators, child-to-child (C2C) groups, and members of the community.



Champion Community awards celebration

Performance was measured based on communal effort and the rate of achievement of objectives set out in community work plans that enabled communities to achieve full Champion Community status. Community fairs were held to publicly celebrate collective achievements and recognize the community's efforts, strengthening their sense of ownership.

Activity 2. Reinforce the technical capacity of the community workers in 44 champion communities

ProVIC ran BCC and family planning trainings for all 400 Champion Community workers which emphasized mobilization and sensitization of communities around HIV/AIDS issues, interpersonal and group communication, managing focus groups, and reaching out to MARPs to encourage the adoption of responsible sexual behaviors and to increase the demand for and the uptake of family planning services.

ProVIC also began work to address the intersection of HIV and tuberculosis (TB). In DRC, TB is the number one killer of people living with HIV/AIDS (PLWHA). Based on current data (*Programme National de Lutte Contre le VIH/SIDA* [PNLS] 2011), it is estimated that around 100,000 persons are screened TB positive every year, out of which 15 percent are co-infected with HIV. In Year 3, ProVIC and the PATH-led TB IQC Task Order 01 (TO2015) project collaborated to strengthen links between HIV and TB programming at the community level by increasing recognition of HIV/TB co-infection, and, in Sud Kivu champion communities, integrating HIV and TB prevention and treatment. For example, members of *Club des Amis Damien* (CAD) were trained in BCC related to HIV and TB, and Champion Community workers were, in turn, trained on BCC related to TB screening. Following these trainings, members of the community facilitated increased integration of HIV prevention activities that addressed topics ranging from family planning and TB to PMTCT.

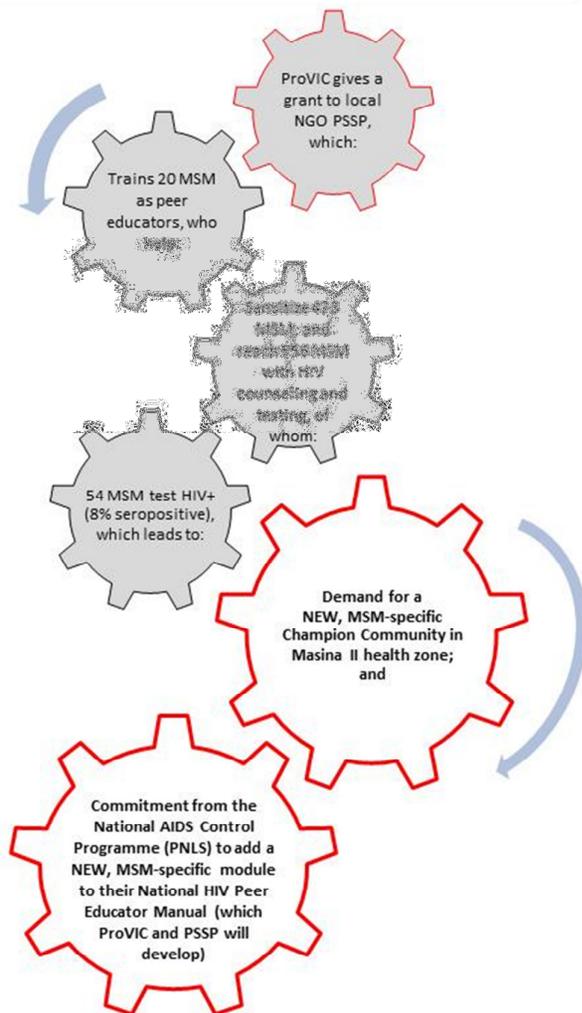
Training modules used for building community worker capacity were also revised and validated through government entities, led by the PNLS, *Programme National de Santé de la Reproduction* (PNSR), and the *Programme National de Lutte contre la Tuberculose* (PNLT).

Local needs, local responses: champion communities in action

WHERE: Kinshasa

CHAMPION COMMUNITIES: Sans-Fil, Matadi Mapela

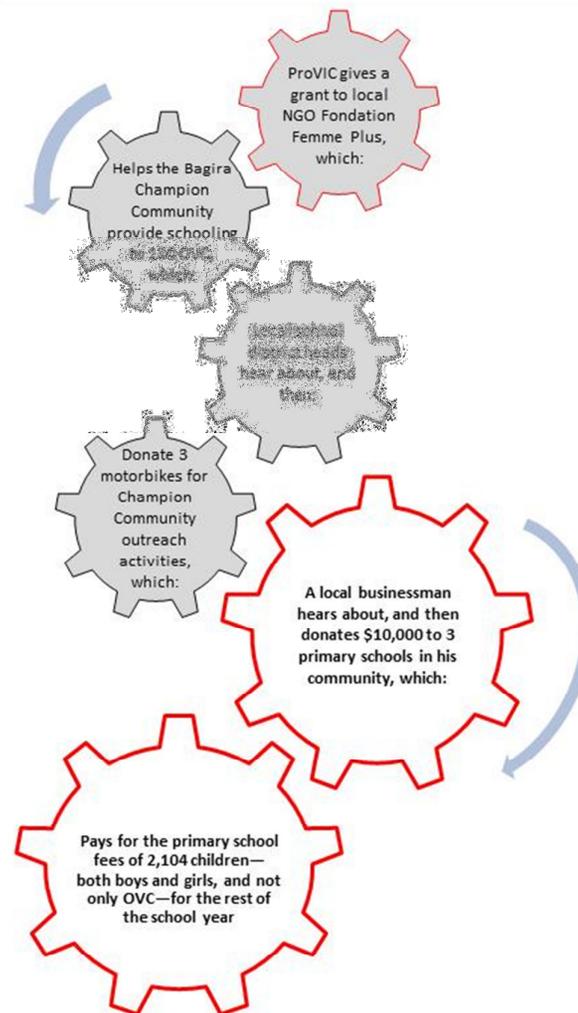
TARGET POPULATION: Men who have sex with men (MSM)



WHERE: Sud Kivu

CHAMPION COMMUNITY: Bagira

TARGET POPULATION: Orphans and vulnerable children (OVC)

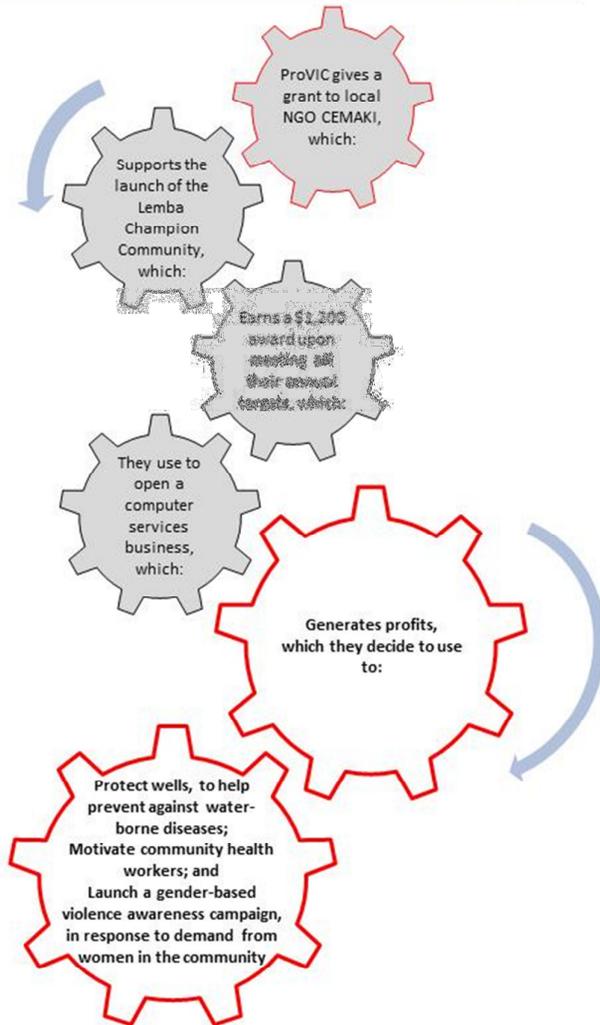


Local needs, local responses: champion communities in action

WHERE: Bas-Congo

CHAMPION COMMUNITY: Lemba

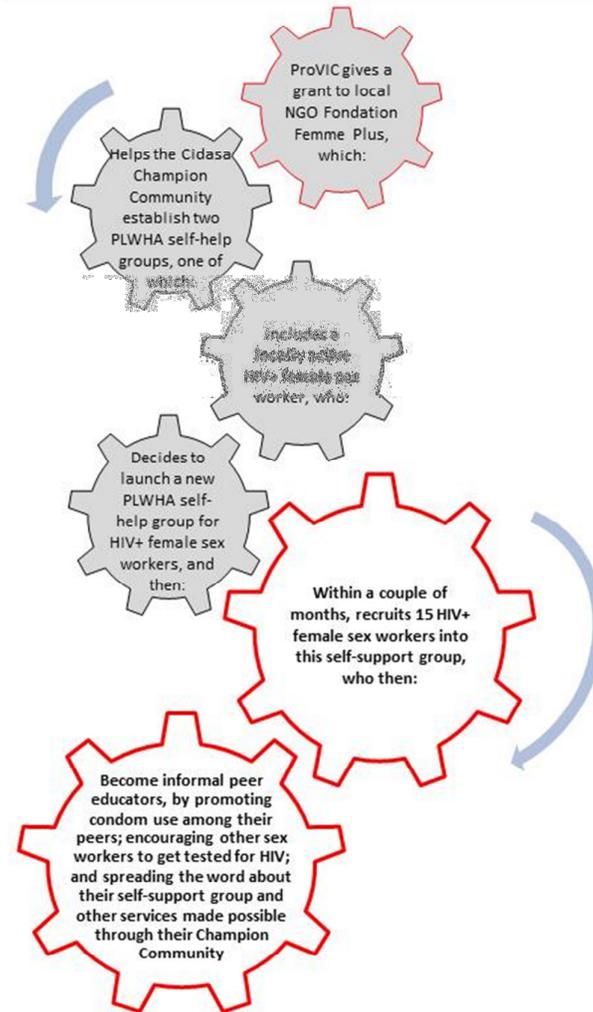
TARGET POPULATION: General population, women, and girls



WHERE: Sud Kivu

CHAMPION COMMUNITY: Cidasa

TARGET POPULATION: Female sex workers



Activity 3. Reinforce the capacity of ProVIC's partners in social and behavior change communication

ProVIC, in coordination with FHI 360's Communication for Change (C-Change) project, has supported capacity-building training in social and behavior change communication for local grantees and NGOs as part of its Champion Community approach. Twenty-seven Champion Community members, partner organizations, and implementing staff were trained in the design of communications messages and materials and in monitoring and evaluation (M&E) of activities based on program objectives. The Champion Community of Maluku has drafted a cartoon for youth in Lingala that conveys messages about HIV prevention and safe sexual behaviors. A draft flyer targeting MSM that shares safe sexual behaviors and HIV prevention messages has been developed with the active involvement of the MSM community.

Activity 4. Support the production and dissemination of communications materials adapted to each area of ProVIC's interventions

As a means to increase visibility, pride, and motivation, all 44 champion communities received kits that included bags, T-shirts, caps, pens, picture boxes, and books (45 kits per community). Other ProVIC communications materials developed, in both English and French, include a ProVIC vision statement brochure and posters for all offices; a visual graphic grounded in the Champion Community approach that illustrates and integrates ProVIC's HIV work across its areas of intervention; and flags to recognize and reward successful champion communities.

AIDSTAR-One selected ProVIC's Champion Community approach as a best practice and developed a case study highlighting lessons learned on ProVIC's model, specifically activities in Kinshasa (Kingasani) and Bas-Congo (Lemba). The AIDSTAR-One team met project stakeholders to collect their views, perceptions, and appreciation of the approach and its impact on the demand and utilization of PMTCT services. Once ProVIC's Champion Community approach is posted on the AIDSTAR website, it will be a reference for other NGOs seeking to replicate aspects of the methodology.

Activity 5. Integrate family planning services into champion communities and youth centers

In accordance with USAID/DRC's Global Health Initiative strategy, ProVIC has integrated family planning services into youth centers in Bas-Congo (Matadi and Boma) and Sud Kivu (Stop-AIDS and Muse). Several consultations with key government ministries (*Programme National pour la Sécurité Alimentaire* [PNSA], the PNSR, and the Ministry of Youth) were organized to assess programmatic needs, harmonize views and approaches to integrate family planning and HIV/AIDS services, and identify youth centers to be integrated into the program.

Based on the finding of these consultations, five-day family planning training sessions were held for 17 service providers who work in youth centers in Bas-Congo and Sud Kivu, in partnership with the PNSR, PNSA, and PNLS. The main topics addressed during these trainings included family planning and HIV/AIDS, adolescent health issues, the consequences of early debut/unprotected sexual activity, sex organs, and contraceptive methods. Subsequently, youth centers, which received family planning products from USAID, were able to provide prevention and family planning services tailored to the needs of youth in the project's champion communities.

Activity 6. Initiate information activities for youth

Due to the delay in establishing the collaborative agreement with the PNSA, targeted Champion Community-driven youth sensitization activities did not take place in Year 3. ProVIC will work through the national youth center structure to more effectively target HIV education for youth during Year 4.

Activity 7. Organize exchange meetings

Exchanges occurred during quarterly coordination meetings.

Activity 8. Participate in World AIDS Day

In December 2011, ProVIC partnered with *Programme National Multisectoriel de Lutte Contre le VIH/SIDA* (PNMLS) to organize HCT and outreach activities in Kinshasa and the provinces. HIV-themed video screenings were organized, which were followed by group discussions and an invitation to get tested. These sessions, which were organized in each Champion Community, promoted and raised awareness around the Joint United Nations Programme on HIV/AIDS (UNAIDS) campaign theme “Getting to Zero: Zero New Infections, Zero Discrimination and Zero AIDS-Related Deaths.”

ProVIC, in partnership with the *Comité Inter Entreprises de Lutte contre le Sida* (CIELS) and the PNMLS, also organized a day of advocacy for children’s rights (December 1, 2011), which was headlined by a speech by the US ambassador to DRC. Activities were aimed at the heads of public and private companies in Kinshasa, and promoted human rights as part of the fight against stigma and discrimination associated with HIV/AIDS. Additionally, PATH launched a corporate World AIDS Day video that included ProVIC activities in DRC.

Activity 9. Continue to conduct regular supervision of community mobilization activities

Throughout Year 3, ProVIC conducted rigorous supervision missions to oversee community mobilization activities, ensure the continued commitment of communities in the fight against HIV/AIDS, and analyze the evolution of the Champion Community model as well as its adaptation. Supervision trips were carried out at different levels: from health zone staff to Champion Community sites; from regional ProVIC office staff to Champion Community sites; and from national technical staff to ProVIC Champion Community sites.

For example, supervision visits to five champion communities in Katanga found strong community involvement in the identification of health issues, collective pride from having been recognized as a Champion Community, and the desire to work hard to achieve results and remain a Champion Community. Staff proposed strategies to community supervisors to streamline operations for smooth implementation.

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

During Year 2, ProVIC continued to work in facility and community-based HCT sites inherited from FHI 360, introducing innovative approaches such as provider-initiated counseling and testing (PICT) at Maria Biamba Mutombo Hospital in Kinshasa and other sites, such as HGR Kenya in Katanga. The mobile HCT experience was also launched in Year 2 to reach out to MARPs and other hard-to-reach populations. The vulnerability and risks-mapping produced by UNAIDS, the United Nations Population Fund (UNFPA), and the

PNMLS helped to identify MSM groups and their sites of operation in Bas-Congo, Katanga, and Sud Kivu. It was in Year 2 that the first MSM started to publicly disclose their sexual orientation and practices.

To build on this work, ProVIC introduced more innovative approaches in Year 3, including:

- Generalized use of the finger-prick technique in supported HCT sites, which enables HIV testing using simple, quick-to-use devices that are less painful to clients and allow a sample to be kept for confirmation of results and for quality control.
- Organization of MSM into networks with training in peer education. One of our grantees, *Progrès Santé Sans Prix* (PSSP), has intensively reached out to MSM to provide them with HIV-related services, screening, and treatment, and referral for sexually transmitted infections (STIs) and opportunistic infections. One virtual Champion Community has been set up as a mechanism to bring MSM together to provide them with HIV/AIDS-related knowledge, best practices, and information on safe and responsible behaviors.
- Organization of nighttime HCT services to reach out to MARPs in their operation sites (e.g., bars, nightclubs, beaches). This model was presented as a best practice at the 2012 International AIDS Conference.
- Introduction of HCT services targeting groups based on the trends of the HIV epidemic: MARPs and people infected with TB, STIs, and opportunistic infections, especially at HGR Kenya in Katanga.
- Implementation of CD4 count by procuring five portable PIMA™ analyzers, one for each province. The use of these machines has facilitated decision-making around whether to put people who test HIV positive on cotrimoxazole (CTX) prophylaxis or to refer them for antiretroviral therapy (ART).

Activities and achievements

Activity 1. Provide support and assistance to 30 HCT sites

In Year 3, HCT project activities took place across 30 sites (Bas-Congo 7; Katanga 10; Kinshasa 7; and Sud Kivu 6) located in 27 health zones. All HCT interventions targeted MARPs and were carried out with government health workers tied to health zones located within Champion Community areas. All HCT sites (mobile, community, and integrated) received tailored support based on each particular province's needs and context, whether this was with respect to specific reagents and commodities, or data collection and management tools. Each site also received joint supervision visits from national ProVIC/PNLS, provincial, and health zone teams.

ProVIC had a target of providing HCT services to 220,000 clients in Year 3. This was part of a larger, more complete package of

Mobile "moonlight" voluntary HIV counseling and testing for men who have sex with men in Kinshasa, Democratic Republic of Congo

Introduction

In the Democratic Republic of Congo (DRC), traditionally stigmatized groups such as men who have sex with men (MSM) are among those most at risk of HIV infection and its burden for service providers to access. In the face of activity of the last, the Integrated HIV/AIDS Project in the DRC (PVoVIC) partnered with the local NGO Progrès Santé Sans Prix (PSSP) to assess the acceptability and feasibility of providing nighttime mobile voluntary HIV counseling and testing (VCT), or "moonlight" testing, to MSM using rapid finger-prick technology.

Why mobile moonlight VCT?

- Mobile sites increase access to HIV prevention services by reaching people where they live and work.
- "Moonlight" VCT sites create a safe space to help reduce stigma and increase demand for services.
- Nighttime testing also means that people do not need to miss work to receive services.

Intervention and Methods

- Risk mapping conducted at 15 sites in Kinshasa in 2010 to identify MSM.
- Social networks and SMS texts used by PSSP, MSM peer educators to recruit clients to mobile VCT sites and raise their demand for testing.
- The mobile VCT sites, each comprising one laboratory technician, one counselor, and a receptionist, delivered a standard mobile night-time VCT clinic in a different HIV hotspot every 2-3 weeks, plus an intervention period.
- One site HIV counseling, testing, and test results provided by mobile VCT sites during demand-driven rapid finger-prick HIV testing allowed MSM to get results quickly.
- Qualitative and quantitative data generated through careful monitoring of mobile VCT attendance, and by soliciting observations from program staff.

Results

- **Initially low MSM attendance:** Only 20 MSM accessed VCT services per night by the end of the six-month intervention.
- **Steady increase in MSM attendance:** An average of 80 clients accessed VCT services every night by the end of the six-month intervention.
- **Very high HIV seroprevalence:** A 30 percent rate among 207 tested MSM aged 20-30 demonstrates the importance of reaching MSM to help prevent the spread of HIV.
- **Critical role of MSM peer educators:** The greatest demand for VCT by signing into their MSM peer networks, creating a "ripple" effect of HIV awareness-raising. Mobile VCT pilot intervention teams reported that MSM peer educators played an important role in conversion.

Conclusions

- **Rapid mobile moonlight VCT for MSM in Kinshasa led to increased service utilization** by expanding access to prevention services and increasing demand through peer education.
- **Client satisfaction reported:** as MSM were pleased to receive prompt, high-quality services without stigma or judgment.
- **MSM peer educators played a critical role** in demonstrating feasibility and effectiveness.
- **Mobile moonlight VCT for MSM expanded** to new additional provinces in 2012.

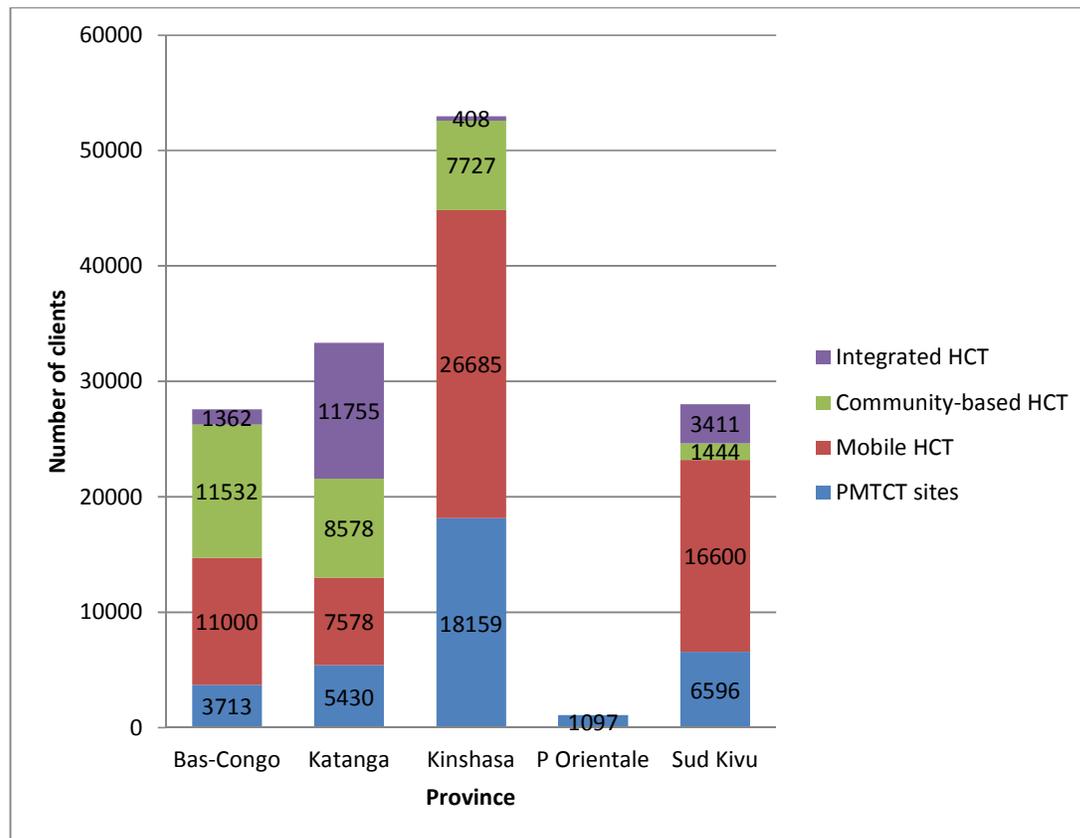
Acknowledgments

This poster was made possible by the generous support of the American people through the President Emergency Plan for AIDS Relief (PEPFAR) and the U.S. Agency for International Development (USAID) under the terms of Contract No. G3H1-09-07-00065-00. Task Order 03. The content is the responsibility of the ProVIC and does not necessarily reflect the views of PEPFAR or the United States government.

HIV services that included testing for TB to address HIV/TB co-infection, PICT, referrals and counter-referrals, quality assurance, and access to other tools to ensure the integrated coordination of services while maintaining the project’s key principles of innovation and sustainability.

A total of 143,075 clients benefited from HCT in Year 3, including pre-test counseling, testing, and post-test counseling upon receipt of results. Figure 2 provides details by HCT type and province. Of note, mobile HCT contributed 43 percent of the clients tested over the course of the year. In Kisangani, Province Orientale, facility-based testing (PMTCT sites) only began in quarter 4; other HCT testing will start in Year 4 as prevention activities are rolled out.

Figure 2. Number of individuals reached, by HCT intervention and by province.



Among those tested, 5,822 (4 percent) were seropositive. Figure 3 shows positivity by HCT type and province, illustrating the importance of having HCT available at different types of access points as well as via outreach methods. The peaks in seropositivity were 6.2 percent for integrated HCT in Bas-Congo, 13.9 percent for integrated HCT in Katanga, and 8.4 percent for community HCT in Kinshasa.

Figure 3. Seropositivity by HCT type.

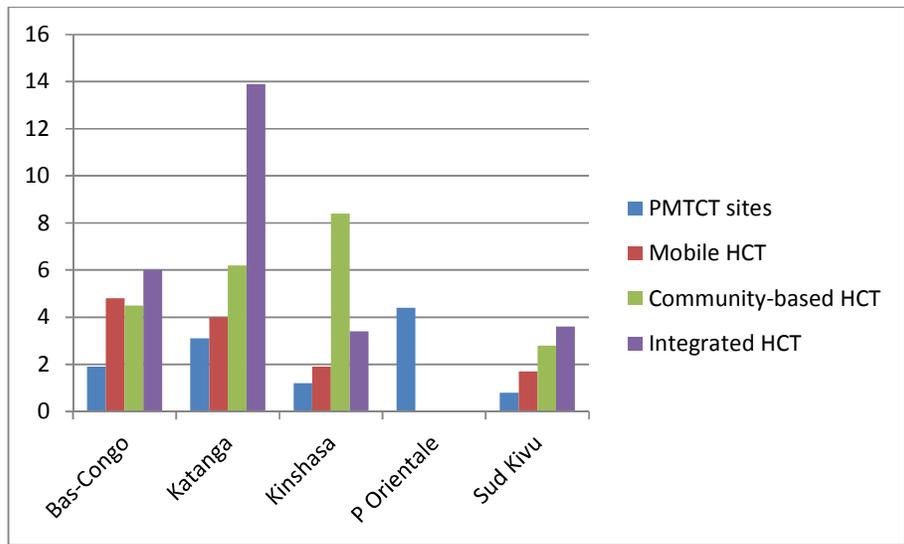


Figure 4 breaks down seropositivity by MARP in specific communities in Bas-Congo. This seropositivity is proportional to the number of clients tested. A larger proportion of CSWs tested positive (37.5 percent) in Nsakala Nsimba (this percentage represents three people out of eight testing HIV positive). However, in other communities where the project does more mobile HCT, more MSM tested positive (25 percent), followed by CSWs (21 percent).

Figure 4. Seropositivity by MARP in several champion communities in Bas-Congo.

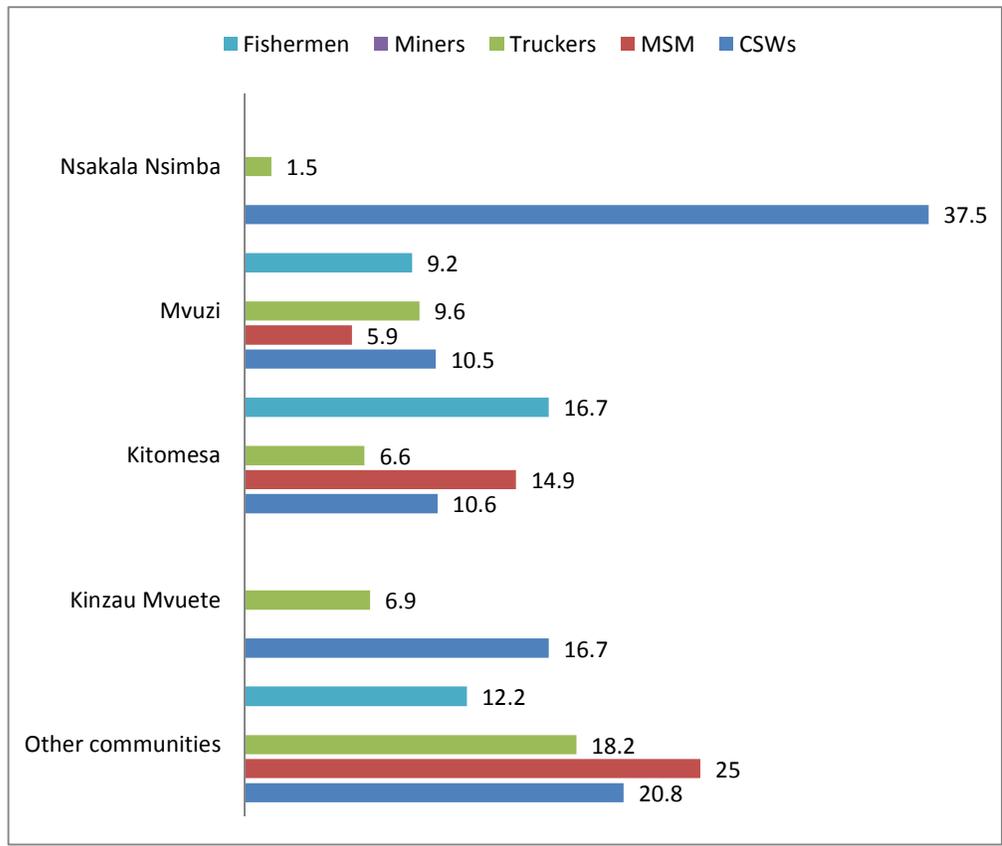


Figure 5 demonstrates the context of the epidemic in each province by traditional categories of MARPs. Seropositivity rates among fishermen in Katanga and Sud Kivu were particularly high, along with rates among MSM in Kinshasa and Sud Kivu, truck drivers in Katanga and Bas-Congo, miners in Katanga, and CSWs in Katanga and Bas-Congo.

Figure 5. Seropositivity by MARP and province.

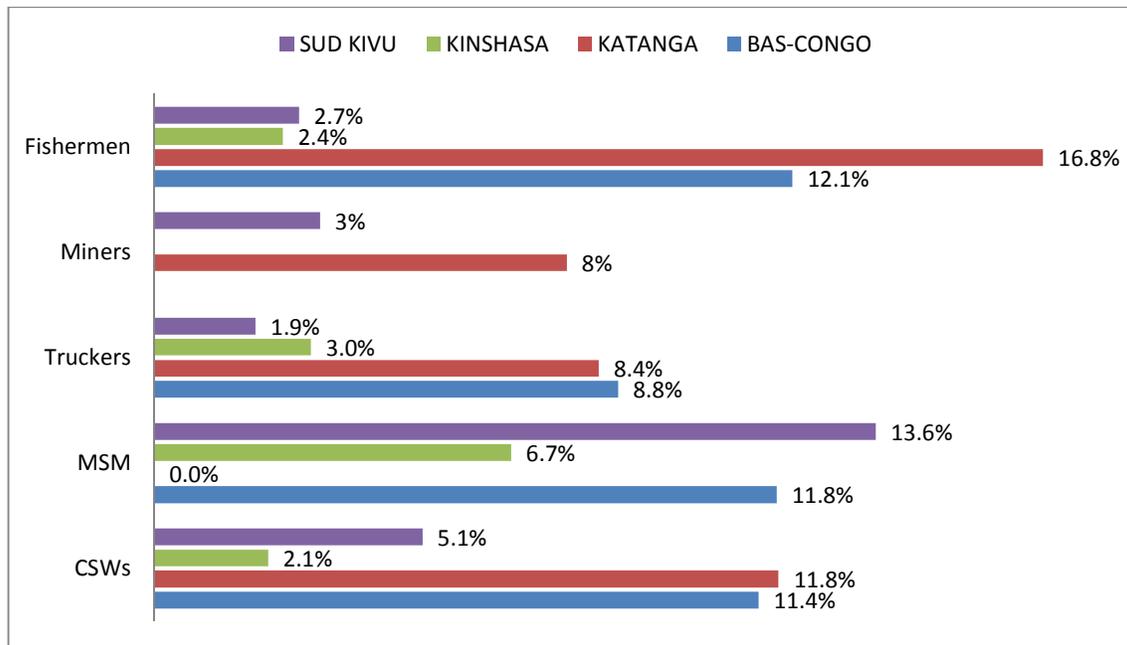
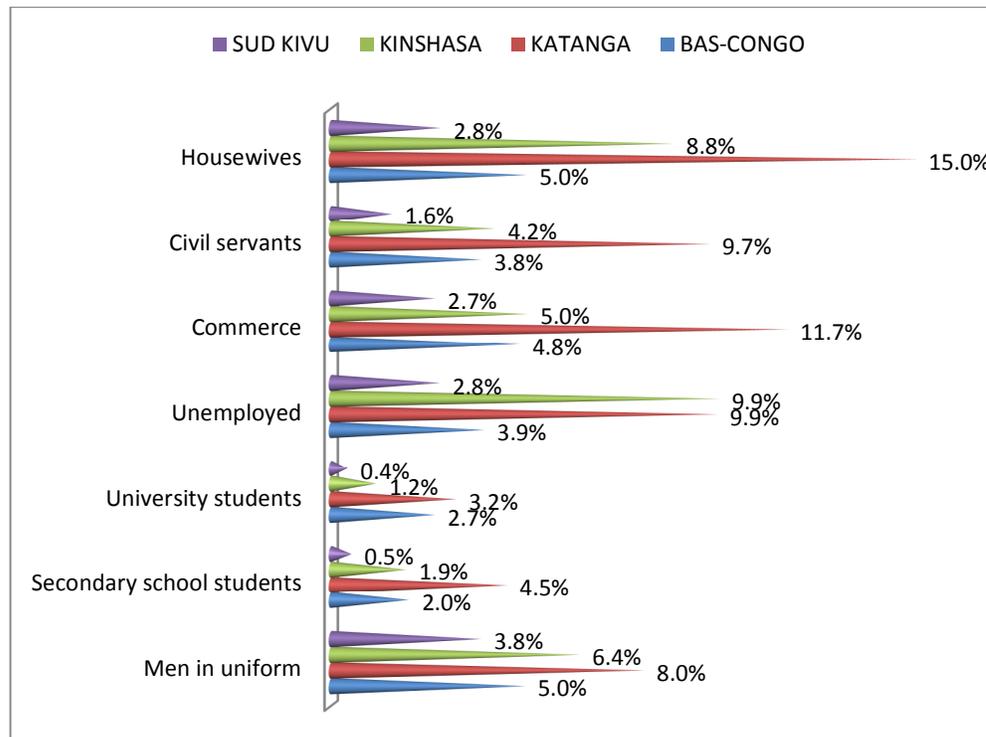


Figure 6 shows other categories of people who are often not targeted, but who are also at high risk for HIV infection. This group includes cleaners and street vendors in Katanga. Going forward, each province will use these data to target its own “most at-risk populations”—those that extend beyond the traditional category. This figure shows not only the context of the epidemic in each province, but also the magnitude of the epidemic. In Katanga, the seroprevalence rates among all categories of “non-traditional MARPs” are very high, peaking among cleaners and vendors and even secondary school students, for whom the rate is 4.8 percent. The situation is also serious in Kinshasa, followed by Bas-Congo and Sud Kivu.

Figure 6. Seropositivity in other HCT client categories, by province.



Further analyzing our data to be able to gain additional insights for targeting HCT, we have found very high rates of seropositivity among young people. Kinshasa has the highest seropositivity rates in people younger than 15 years (18 percent), followed closely by Katanga (16 percent). Katanga has the highest rates in the 15 to 24 age group (3.3 percent).

Activity 2. Integrate family planning into HCT sites

ProVIC’s vision consists of facilitating access to and use of family planning methods in all 44 champion communities. In DRC, the contraceptive prevalence rate is estimated at 5.8 percent (PNSR 2010). Family planning methods are known to provide double protection: (1) they help to prevent HIV and other STIs and the infection of sex partners; and (2) they prevent unwanted pregnancies. For people who test HIV negative, family planning offers the possibility to enjoy protected and safe sexual activities, to avoid multiple sex partners, and to plan accordingly on the number of children desired. For PLWHA, family planning prevents the infection of HIV-negative partners and multiple infection of PLWHA. At all its HCT sites, ProVIC provides clients with necessary information and basic knowledge on family planning, and distributes condoms and explains the importance of their proper use.

In Year 3, ProVIC conducted an assessment of current family planning services provided at each of our HCT sites. Project staff collected information on the capacity of current service providers (number of staff previously trained in family planning), availability of family planning commodities at current sites (volume, types of family planning methods, expiration dates, and sources of funding), and data collection tools and methods currently being used. Findings varied from one site to another, with some sites offering fully integrated family planning services and some offering only a few services and methods. Bas-Congo and Katanga were the first to benefit from this integration, especially in PMTCT and HCT sites. A combined PMTCT/family planning training was conjointly organized by Population

Services International (PSI) for family planning and FHI 360 for PMTCT/HCT. In addition, family planning commodities provided by USAID were distributed to all supported HCT and PMTCT sites. A collection and reporting tool was developed and is awaiting validation by the PNSR and PNLS.

These results were presented at a meeting with USAID Family Planning/Reproductive Health Specialist Thibaut Mukaba in October 2012, when the project expressed the need for service provider training and supplies such as male and female condoms, oral contraceptives, implants, injectables, and cycle beads. HCT and PMTCT services now include use of data collection and family planning tools, which were integrated into training that was provided for 24 HCT service providers in the provinces of Bas-Congo, Katanga, and Sud Kivu. Each HCT site across the three provinces was also provided with family planning commodities and methods received from USAID.

Activity 3. Ensure regular supply of commodities, including laboratory tests and accessories, to HCT sites

In FY12, ProVIC began coordination with the Supply Chain Management System (SCMS) project for the procurement, transport, and distribution of commodities for ProVIC. After some initial delays, due to SCMS underestimating the time for customs clearance in DRC, the quantification and procurement of commodities and supplies has shown clear signs of improvement. In FY12, ProVIC quantified and procured HIV tests, antiretroviral medications (ARVs), laboratory supplies, and equipment through SCMS in Kinshasa and then distributed to its other four provinces.

In spite of the improvement, ProVIC suffered a significant setback when its final “pre-SCMS” order, which was delayed at the airport warehouse for two months awaiting clearance and exoneration, experienced a theft. Upon arrival at the ProVIC offices, the expected shipment of 50,000 HIV tests was, in fact, 13 boxes which had been emptied of HIV tests and replaced with expired drugs and dusty medical supplies. A police report was made and an investigation began, all in close coordination with USAID. This situation is presently ongoing and has prevented ProVIC from reaching its stated targets.



A community worker with HCT supplies at a ProVIC mobile testing site in Matadi, Bas-Congo (photo: ProVIC/PATH).

Better targeting of capable local commodity suppliers is a lesson learned from previous stockout experiences. Instituting a monthly commodity reporting system, which was adapted from the Management Sciences for Health (MSH)/Strengthening Pharmaceutical Systems project, has allowed ProVIC to quickly quantify average monthly commodity consumption by site, also alerting staff when stocks are low to avoid ruptures in commodity stocks.

In addition and for a better commodity management system, ProVIC decided to sign contracts with regional distributors in each province. In Year 3, Katanga signed a contract with CAMELU, Bas-Congo with CAMEBO, and Kinshasa has been in negotiations with CAMESKIN.

Activity 4. Reinforce the link between HCT services and TB services in champion communities

TB is the number one cause of mortality for PLWHA. ProVIC's integrated model includes linkages between HCT and TB screening, diagnosis, and treatment. ProVIC established linkages between TB and HIV/AIDS activities by convening five meetings with the PATH TO2015 project in Year 3. Among the outcomes of these planning efforts was the development of a HIV/TB co-infection checklist that was then submitted for adoption by the PNL. In addition, the development of referral and counter-referral systems for patients was set in motion in ProVIC health zones in close consultation with TB protocols and management structures for TB patients, along with both HCT and TB service providers. ProVIC has also benefited from strong engagement of National Anti-Leprosy and Anti-Tuberculosis League staff, who participated in ProVIC HCT trainings.

Synergies and linkages created between ProVIC and PATH's TO2015 project during this period allowed Bukavu-based TB diagnostic and treatment center service providers to successfully participate in HIV testing, mobile HCT, and HCT commodity management trainings for Champion Community members.

Activities 5 and 6. Make HCT tools available; Ensure the quality of HCT services in sponsored sites

Building on lessons from the project's first two years, during Year 3, ProVIC focused its efforts on improving the quality of HCT services, particularly for MARPs. Thirty HIV testing sites (Bas-Congo 7; Katanga 10; Kinshasa 7; Sud Kivu 6) are now providing high-quality HCT services that target MARPs, such as CSWs, MSM, fishermen, miners, and long-distance truck drivers, depending on the unique demographics of each ProVIC operating region. Finger-prick technology is being used at mobile voluntary HCT sites, and the project's "moonlight" HCT work has generated particular interest among MARPs by providing quicker and easier access to services, and was presented at the 2012 International AIDS Conference as an innovative model.

In Year 3, the ProVIC HCT team led trainings of laboratory technicians responsible for blood drawing at testing sites as part of ProVIC's broader mission to strengthen the quality of project-supported services. These trainings supported the establishment of a quality assurance system that ensures accurate results using quality control checks such as random sampling to verify both positive and negative samples. Technical assistance was provided to ensure the quality of blood samples, handling, storage, and transportation. As a follow-up to these trainings, the ProVIC prevention and HCT teams set up internal and external quality controls for each HCT site by establishing quarterly joint formative supervision visits with the National HIV Referral Laboratory. Lastly, a series of data quality assessments (DQAs) was conducted at two HCT sites in Kinshasa (AMO-Congo and PSSP) in collaboration with ProVIC's National M&E Specialist.

In addition, the HCT and Health Systems Strengthening (HSS) teams have worked closely with the PNL, PNSR, and PNL to put in place referral and counter-referral systems and tools at HCT sites to better manage HIV/TB co-infection, family planning, and sexual and

gender-based violence (SGBV). All related HCT tools recommended by the PNLS were reproduced and used at ProVIC HCT sites.

Finally, in January 2012 and to further support ProVIC’s mission to ensure access to high-quality HIV services for MARPs, the project’s senior technical staff participated in a USAID-sponsored workshop entitled “HIV Prevention, Care, and Treatment for Men Who have Sex with Men (MSM) in Africa: A Review of Evidence-Based Findings and Best Practices in South Africa.” Lessons learned from this workshop have informed ProVIC’s continued exploration into the possibility of designing and launching a discrete MSM program tailored to the DRC context—a country with few on-the-ground partners whose work specifically targets this MARP. The lessons have also given impetus to ProVIC staff members who are advocating to put in place measures that address specific MSM needs as part of the National HIV/AIDS Strategic Plan. Since this workshop, ProVIC improved its package of MSM-targeted HCT services through efforts such as including lubricant in prevention packets distributed to clients, and by intensifying referrals for STIs and other anal-based infection screening and treatment. In addition to prevention, sensitization, and peer education, ProVIC began exploring legal protection services for MSM, as well as organizational support to set up community-based MSM networks and peer support groups.

Activity 7. Promote the utilization of the finger-prick technique in ProVIC sites

During Year 3, ProVIC expanded the use of rapid finger-prick technology at HCT sites as a way to introduce incremental efficiencies and cost savings. Building on Year 2 finger-prick technology trainings in Kinshasa and Katanga, the ProVIC HCT team trained 21 service providers in Sud Kivu. Since, ProVIC staff have observed improved technical application among trained service providers. These measures will help ensure the correct, effective use of rapid finger-prick blood draw technology, which will be further supported by quality improvement and quality assurance work. Additional finger-prick technology training materials were ordered and received by ProVIC for training at eight HCT sites, where national and provincial ProVIC HCT staff worked with PNLS laboratory technicians to provide technical support to HCT site teams. In Bas-Congo, training follow-up emphasized stronger management and oversight of testing procedures during the project’s initial training of HCT service providers.

Much of the technical assistance for HCT service providers was done in close collaboration with provincial PNLS laboratory staff. To ensure quality, Regional Coordinators and M&E Specialists attended monthly coordination and data validation meetings, while implementing partners attended similar meetings at the provincial and health zone levels. National ProVIC staff also made three supervision visits per province to Katanga, Kinshasa, and Sud Kivu, while provincial prevention and HCT Specialists continued monthly visits to each HCT site. These visits included technical oversight and real-time support to partners, thereby building their technical and organizational capacity to manage provider-based voluntary counseling and testing (VCT)



A community worker uses finger-prick technology to administer a rapid HIV test (photo: Chemonics).

services, integrate family planning activities into prevention and HCT activities, increase access to MARPs through mobile VCT, and improve referral and counter-referral systems for HIV-positive cases.

This technology was applied to ProVIC’s innovative work accessing MARPs through mobile HCT services—particularly at night to reach CSWs and MSM where they live and operate. Training of mobile HCT workers on the use of finger-prick technology is reducing costs and improving the efficiency of HCT services.

Activity 8. Coordinate prevention and HCT activities with partners

As part of ProVIC’s ongoing efforts to strengthen the capacity of HCT service providers, the project’s prevention and HCT Specialists organized three site visits per province to Katanga, Kinshasa, and Sud Kivu, which allowed staff to jointly review partners’ work plans, progress toward expected results, and the quality of services provided to clients. Provincial PNLs, PNMLS, and *Equipe Cadre de la Zone de Santé* (Health Zone Management Team, or ECZS) joint supervision visits were made to all 30 HCT sites, identifying and addressing gaps in prevention policies and protocols. Identified gaps such as the improper use of rapid tests and data collection and reporting tools, as well as the misinterpretation of results, were discussed and addressed during trip debriefings with partners and service providers. Appropriate corrective actions were taken through training and other technical assistance as described in Table 1.

Table 1. HCT-related technical assistance provided by ProVIC, by province.

	Bas-Congo, Katanga, Kinshasa, and Sud Kivu
Type of technical assistance	Rapid testing using finger-prick technology
	DCIP refresher on service provider-initiated screening and counseling
	Biological diagnostic strategies at HCT sites (strategies I, II, III)
	Logistics and commodities management
	Mobile HCT strategies to reach MARPs
	Data collection and management
	Organization of prevention activities for MSM

DCIP: *Dépistage Conseil Initié par le Prestataire*.

ProVIC staff also participated in several PNLs/PNMLS nationally and provincially led meetings with DRC prevention and HCT experts. Meeting outcomes were gleaned from reports that highlighted national PNLs/PNMLS staff participation in joint prevention and HCT supervision visits—to nighttime mobile HCT activities in particular. This resulted in a request for broader ProVIC dissemination of “moonlight” HCT work to other partners, including integrating this work into national HCT protocols.

Activity 9. Provide CD4 counts to clients who test HIV positive in HCT sites

In Year 3, ProVIC purchased five portable PIMA™ analyzers for CD4 count to be used in HCT sites. Each ProVIC province has received one machine, which is being used to assess the eligibility of HCT clients and immediately place HIV-positive individuals on prophylaxis such as CTX or ARVs, depending on the diagnosis. ProVIC also received 28 PIMA™ analyzers under the PMTCT Acceleration Program, which have been distributed as follows: four to Bas-Congo, seven to Katanga, ten to Kinshasa, three to Kisangani, and four to Sud Kivu.

Sub-IR 1.3: PMTCT services improved

In its first two years, ProVIC was a key player at the national level, advising the PNLs and the Ministry of Health (MOH) on the most efficient and cost-effective way of adapting the 2010 World Health Organization (WHO) guidelines for PMTCT and infant feeding into DRC's national protocols. Following the adaptation of the new guidelines, ProVIC then took the lead on updating the national integrated HIV training materials according to the new standards. During this time, ProVIC became the first PMTCT implementing partner in DRC to offer PMTCT prophylaxis according to the new national and international standards at 100 percent of its PMTCT sites. During Year 3, ProVIC began preparing sites to implement PMTCT using the Peer-to-Peer Local Capacity Development (LCD) model as part of PEPFAR's PMTCT Acceleration efforts in DRC. ProVIC was one of the US government's largest participants in the PMTCT Acceleration efforts. Under the PMTCT Acceleration Program, ProVIC made plans to double its key targets of pregnant women tested for HIV and number of pregnant women provided with prophylaxis or ART. ProVIC also led the national PMTCT Technical Working Group (TWG) through the process of updating PMTCT data collection tools to capture data and information on PMTCT services according to the new national standards.

The PMTCT standards being implemented by ProVIC start HIV-positive pregnant women on PMTCT prophylaxis earlier than previous guidelines, which will lead to lower rates of transmission. Clinically eligible HIV-positive pregnant women (those with CD4 counts below 350cells/mm) are started on ART immediately. Untreated women who are clinically eligible for ART have the highest rates of transmission to their infants, but by putting them on ART for their own health, the ProVIC project should substantially reduce mother-to-child transmission. In addition to providing clinical services which meet the highest international standards, ProVIC has also led the way with innovations to link communities to PMTCT and EID services. While DRC is making strides at the national level in planning to eliminate pediatric HIV (with the drafting and finalization of the national plan to eliminate pediatric HIV), analysis of the plans have revealed that community linkages remains a major gap in DRC's plan. ProVIC seeks to be a model of how to link communities to PMTCT services, and is using the Champion Community model to lead this effort, and will pilot a Mentor Mother model in Year 4, which will also reinforce community linkages to PMTCT services.

ProVIC has been a national leader in strengthening systems for EID, and for linking exposed infants to care and treatment. When DNA polymerase chain reaction (PCR) testing for EID first became available in DRC in 2010, ProVIC led the development of a nationwide system to deliver dried blood spot samples from facilities to the national reference laboratory in Kinshasa, and back to sites and families. The ProVIC PMTCT team continued to work with providers and health zones in the last year to troubleshoot this system and focus on reducing the turnaround time for results, and to ensure that samples were taken correctly and could be read accurately in the laboratory. One of the greatest challenges surrounding EID in DRC remains the identification of HIV-exposed infants and ensuring that they are connected to available care and treatment services. ProVIC has been working to address this problem in innovative ways, using champion communities to increase community awareness of available services, and working at the national level to introduce notations on the child health card which note their exposure status. ProVIC has also been working to "recover" exposed infants using screening at the well-baby visit—essentially using the platform of a health service which is generally well attended in DRC (for early childhood vaccinations) and integrating HIV services to identify and test infants who have been exposed to HIV. Another innovation

at the national level that has been guided by ProVIC has been the development of joint mother-baby tracking tools. In these ways, ProVIC continues to lead innovative HIV programming in DRC, working from the community level to the national level to improve service quality and integration and increase access.

Activities and achievements

Activity 1. Strengthen the capacity of government to provide PMTCT services

During Year 3, the ProVIC PMTCT team assumed a leadership role at numerous national-level meetings and workshops with partners involved in HIV activities in DRC (see Table 2). These meetings aimed to reinforce and strengthen the capacity of the DRC government to provide and supervise high-quality PMTCT and pediatric care services for children affected by HIV.

In January 2012, ProVIC participated in a workshop to review and refine a draft plan for the elimination of pediatric HIV in the country. The elimination plan was drafted at the national level based on the results of an analysis of programmatic bottlenecks and service disparities across DRC's various provinces. The elimination plan identifies strategies and programmatic priorities for reducing the number of new infections among children younger than 15 years by 90 percent by 2015. The plan also aims to reduce the number of maternal and infant deaths associated with HIV by 50 percent by 2015. Ideally, in addition, the plan will also serve as an advocacy tool among the government and its PMTCT partners for mobilizing political will and resources for increased support to women, children, and families affected by HIV.

Following DRC's loss of its application for Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) Round 10 funding and commodities, the ProVIC PMTCT team provided substantial technical assistance to the PNLs to prepare an application for Round 11. While this application was originally scheduled for March 2012, the Global Fund canceled Round 11 in November 2011 due to budgetary constraints.

During Year 3, ProVIC leveraged the PMTCT TWG as a forum for providing a strong voice in strengthening the DRC government's capacity to adapt the guidelines, strategies, and tools needed to provide the most effective PMTCT services to women and exposed infants. After the adaptation of new national guidelines to meet WHO's new recommendations for PMTCT, ProVIC, in collaboration with partners such as FHI 360 and PEPFAR implementing partners, worked with the DRC government to revise existing registers for the collection of newly mandated clinical data and participated in the validation of the national PMTCT data collection tools, bringing them into alignment with DRC's new PMTCT guidelines. The updated tools include an HIV-integrated antenatal care register, antenatal consultation form, antenatal consultation log, delivery room log, exposed child follow-up form, and log for other family members. These tools were adapted with leadership by ProVIC using experiences from other Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) country programs. After the tools were developed and piloted, the ProVIC PMTCT team continued to assist the MOH in finalization prior to printing and distribution to all ProVIC-supported sites.

Table 2. Illustrative national meetings where ProVIC provided PMTCT technical assistance to the DRC government.

Topic	Participants	Period
Exchange and coordination of distribution of PMTCT sites under PEPFAR's PMTCT Acceleration Program	PNLS, MSH, and PEPFAR implementing partners	March–May 2012
Workshop to revise the national PMTCT training module in accordance with new national guidelines for PMTCT	PNLS and national HIV partners	May 2012
Harmonization for the training of trainers and the cascade of training of providers in the new integrated HIV training manual	PNLS and PEPFAR implementing partners	May–September 2012
National PMTCT and pediatric care and treatment, and revision of maternal and child health tools	MOH/PNLS, UNICEF, WHO, and PNLS	June, July 2012
Start-up meeting to discuss increasing pediatric care and treatment services	PNLS and other partners	August 2012
Presentation of ProVIC work plan and discussion of potential areas of collaboration with the PNLS	Provincial PNLS, Kinshasa	September 2012
Coordination meeting for the follow-up of PMTCT implementation	PNLS and PEPFAR implementing partners	Quarterly

UNICEF: United Nations Children's Fund.

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

During Year 3, ProVIC focused efforts on increasing the promotion and uptake of pediatric counseling and testing and improving the follow-up of mother-infant pairs. Given the fractured health system in DRC and the fact that clients frequently seek services at multiple venues, retaining mother-infant pairs in PMTCT and HIV care services is a significant challenge. To complicate matters, social and economic barriers such as stigma and lack of money for transportation often cause HIV-positive mothers to skip services or go to new sites where they are unknown, making it difficult for programs to improve retention. In Year 3, ProVIC's innovative Champion Community program helped with messaging on these issues. As a result of these and other efforts, indicators which can act as a proxy for mother-infant follow-up have improved significantly. For instance, the number of infants placed on CTX within two months is a good indicator of mother-infant pair retention, as it shows women who have been through the PMTCT system and then present with their child at the young child visit for EID. In Year 1, only two children met this criteria (it must also be noted that DRC's EID machines were not in place for most of Year 1). In Year 2, this increased to 71; and in Year 3, the number rose to 252, showing a marked improvement in retention. ProVIC worked hard to ensure effective referrals of infected infants to treatment and initiation of HIV-exposed infants on CTX. The referral system for placing HIV-infected children on ART, set up during the first year of ProVIC activities, was strengthened by the introduction of phone calls to reach mothers, and by establishing a management structure wherein referred women are followed up to determine if the referral was successful.

During Year 3, more and more exposed infants in Bas-Congo, Bukavu, Katanga, and Kinshasa continued to be identified earlier using PCR DNA analysis for EID at 6 weeks of age. Once identified as HIV positive, infants were referred to either a Global Fund or Clinton Foundation facility where drugs for pediatric treatment were available. During the first half of Year 3, ProVIC continued to provide CTX to prevent opportunistic infections in both HIV-positive pregnant women and exposed children. All ProVIC facilities initiated CTX for HIV-

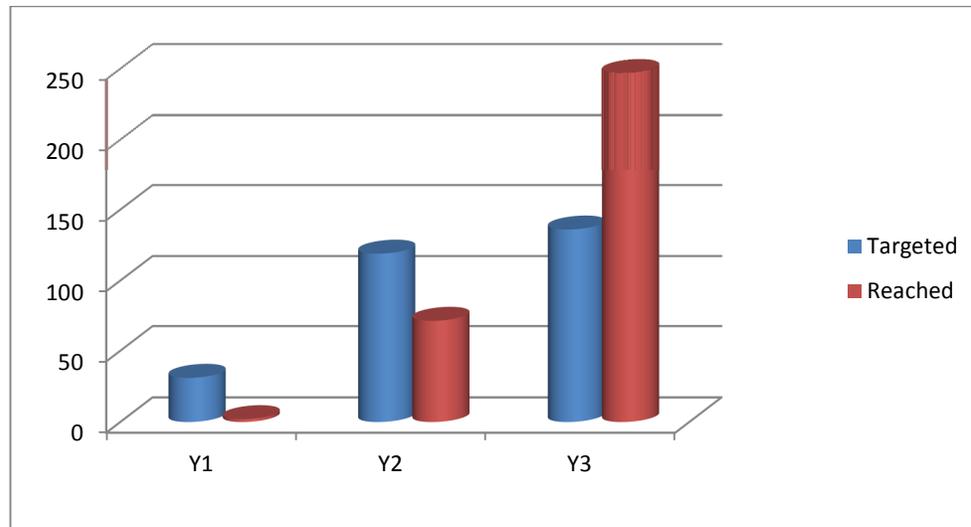
positive women immediately upon receipt of a positive test or when a known positive woman presented at a PMTCT site, and for exposed infants starting at 6 weeks. In addition, testing before 12 months also saw a marked improvement. In Year 1, only 18 infants were tested prior to 12 months of age; in Year 2, this figure rose dramatically to 187; and in Year 3, ProVIC reached 381 children prior to 12 months of age with HIV testing.

Year 3 activities included efforts to reinforce the system for follow-up of mother-infant pairs throughout the PMTCT cascade. To support these efforts, job aids developed by the ProVIC PMTCT team in Year 1 continued to be used by providers at ProVIC PMTCT sites. In addition, strategies for reducing loss to follow-up, such as phone calls from providers to clients, and home visits to track clients not reachable by phone, were used and encouraged. ProVIC continued to support providers with phone credit for client communication and transportation allowances for home visits. Anecdotal evidence indicates that this initiative visibly improved program retention and quality of care for clients under the ProVIC program.

The Senior and Provincial Pediatric Specialists continued to reinforce and troubleshoot the EID system developed in Year 1, ensuring smooth collection and shipment of samples to Kinshasa for testing and efficient return of results to both clinic staff and families. The Senior Pediatric Specialist worked with the National PNLs Laboratory to reduce turnaround time for the EID tests and continued to reinforce referral systems for linking infected infants to treatment. The team also worked to improve the quality of care for infected infants by increasing the proportion of infected infants on treatment and the number of exposed infants receiving CTX prophylaxis.

An analysis of the results from Year 3 data on infants receiving CTX at 6 weeks is very encouraging; infants placed on CTX exceeded the annual target projected by the project in Year 2 (see Figure 7). The better-than-expected result in Year 3 is partially attributable to the integration of messages on the importance of mother-infant follow-up after receipt of PMTCT services into Champion Community messaging.

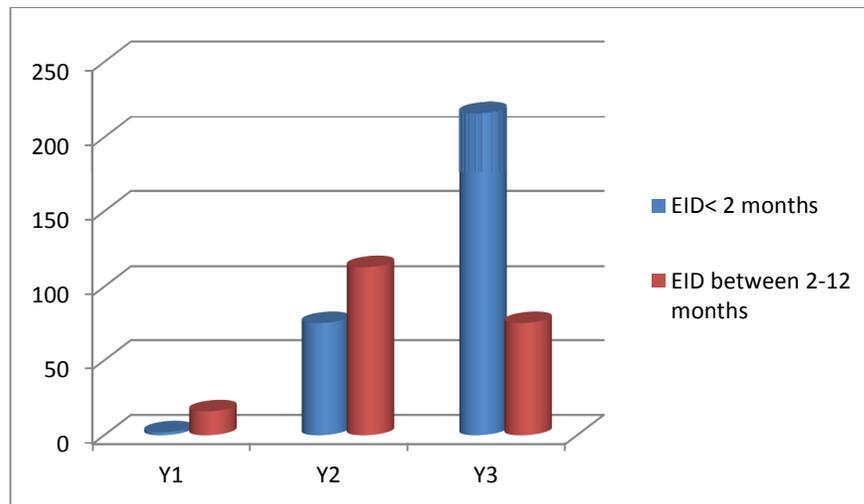
Figure 7. Initiating CTX with exposed infants at 6 weeks of life, Years 1 through 3.



In Year 3, community health workers also encouraged mothers to return with exposed infants for the young child visit at the PMTCT site, to allow for growth monitoring, clinical follow-

up for HIV, provision of CTX, and HIV testing for the child. This integration improved the earliest testing for infants, as shown in Figure 8.

Figure 8. Annual EID trend.



Despite this improvement in the rates of exposed children started on CTX at 6 weeks of age and on EID, a weakness remains in the successful referral of infected children testing positive to care and treatment centers. It is thought that economic and social barriers such as cost of transportation, fear of stigma, and lack of clear communication from provider to client inhibit successful referral. This weakness will be one of the major focuses of ProVIC in Year 4, and the Mentor Mother pilot is expected to play a role in increasing successful referrals.

Activity 3. Provide technical assistance and capacity-building in PMTCT to *Projet de Santé Intégré* sites that are located in geographic areas targeted by ProVIC

In the first quarter of Year 3, the ProVIC PMTCT team provided technical assistance to *Projet de Santé Intégré* (PROSANI) PMTCT sites to support their transition to the new national PMTCT guidelines. The ProVIC PMTCT team reinforced the capacity of both the national PROSANI team and PROSANI’s provincial supervisors on the implementation of the new guidelines in DRC.

During biweekly meetings with the PROSANI HIV Officer, the ProVIC PMTCT team shared their experiences, challenges, and ideas on how to address challenges—such as how to remedy the duplicative and multiple data collection tools being used at various sites—while the MOH was in the process of harmonizing these tools among partners. This national-level process, aimed at creating a single set of integrated data collection tools for use by all sites and partners, began during the first quarter of Year 3 under the guidance of the PNLs, EGPAF, ProVIC, and FHI 360. In the meantime, ProVIC provided technical assistance to PROSANI to adapt their data collection tools for more accurate data collection by health service providers.

In Year 3, ProVIC also provided technical assistance to PROSANI in implementing EID at PROSANI sites to increase demand for and uptake of EID services. During working meetings with the PROSANI team, the ProVIC PMTCT team discussed strategies to create an EID network to serve PROSANI PMTCT facilities using ProVIC’s EID network as an example.

By the end of Year 3, ProVIC had increased the capacity of the PROSANI team to implement PMTCT services according to the new national guidelines, and to collect data using the new national forms. The USAID team subsequently requested that ProVIC cease the provision of technical assistance to PROSANI and instead focus all attention on ProVIC PMTCT sites during Years 4 and 5.

Activity 4. Increase the quality of PMTCT services

Ensuring not only access to PMTCT services, but also the quality of these services, remained a major priority for ProVIC at the 16 PMTCT sites where it operated in FY12 (see Table 3 for information on sites). Under PEPFAR’s PMTCT Acceleration Program, ProVIC identified an additional 25 new sites, to bring the total to 41. Agreements were developed with these sites to ensure high-quality implementation, which will begin, in most cases, in October 2012. ProVIC offered integrated HIV trainings to bring providers at the new sites up to date with the new PMTCT implementation standards. In the second quarter, providers in Bas-Congo and Sud Kivu received this training, and PMTCT activities began in two new PMTCT Acceleration sites, HGR Bagira and HGR Nyantende.

Participants for the trainings of trainers (TOTs) in Katanga, Kinshasa, and Kisangani were selected and trained in May 2012. Trainings of providers (TOPs) followed in the third quarter for 120 providers, with TOT trainees serving as trainers for TOP sessions, in collaboration with the PNLs and FHI 360. In addition, 157 providers received training in family planning. The ProVIC PMTCT team also used the TOPs as an opportunity to train laboratory technicians in EID.

During Year 3, the ProVIC PMTCT team developed a plan to implement a central/satellite model or Peer-to-Peer LCD model as part of the planned PMTCT expansion under the Acceleration. Existing ProVIC sites will serve as central hubs, and a network of peripheral sites will be developed around them. The central sites will reinforce the capacity of the peripheral (or “partner”) sites to provide high-quality PMTCT services.

Table 3. ProVIC-supported PMTCT sites in Year 3.

Province	Existing sites	New sites	Central	Partner	Total
Kinshasa	4	4	5	3	8
Katanga	5	10	7	8	15
Bas-Congo	5	2	4	3	7
Sud Kivu	2	3	3	2	5
Province Orientale	0	6	3	3	6
Total	16	25	22	19	41

There was a delay in the start-up of Acceleration sites in Year 3, primarily due to a delay in the rollout of the TOTs (managed under FHI 360), but also as the result of delays in the signature of site agreements with certain health structures. Initial targets for Year 3 were to implement PMTCT activities at 41 ProVIC sites and to test 50,000 pregnant women for HIV during antenatal care and labor and delivery. This target was not met due to the above-mentioned challenges.

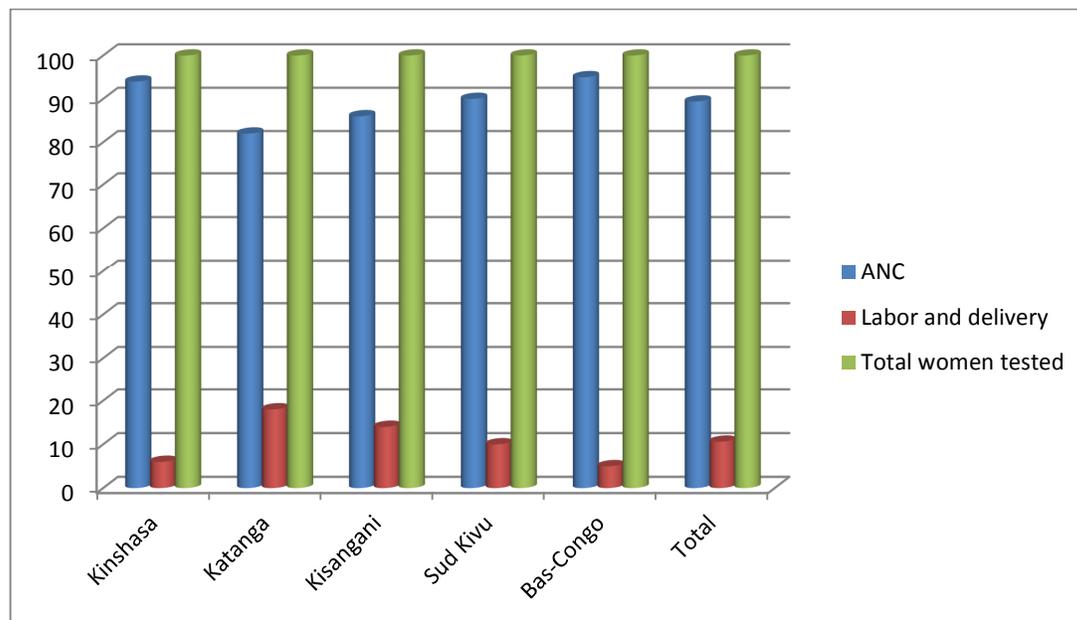
Despite the delay, the ProVIC PMTCT team did work to reinforce linkages between all four prongs of PMTCT and reinforce linkages between all services supported by the project. For example, all pregnant women were given an opportunity to discuss family planning with their health care provider. During Year 3, the Kinshasa PMTCT team and the Provincial

Prevention Specialists provided sites with commodities purchased by the consortium, organized onsite training for providers, and ensured follow-up so that all HIV-positive pregnant women and their infants could access ARV prophylaxis and treatment according to the new national guidelines.

During the second and third quarters, the Kinshasa PMTCT team worked with clinic staff to strengthen primary prevention counseling for HIV-negative women during the traditional three-day postpartum stay at maternities. The PMTCT and Senior Pediatric Specialists conducted follow-up visits to support the quality of PMTCT services and to ensure that gendered approaches such as male involvement, equitable access to health services, and female empowerment were being successfully integrated into PMTCT strategies. Throughout the year, the team continued to monitor the correct disposal of medical waste at PMTCT sites. PMTCT services were strengthened with continued support for PICT during home visits by providers.

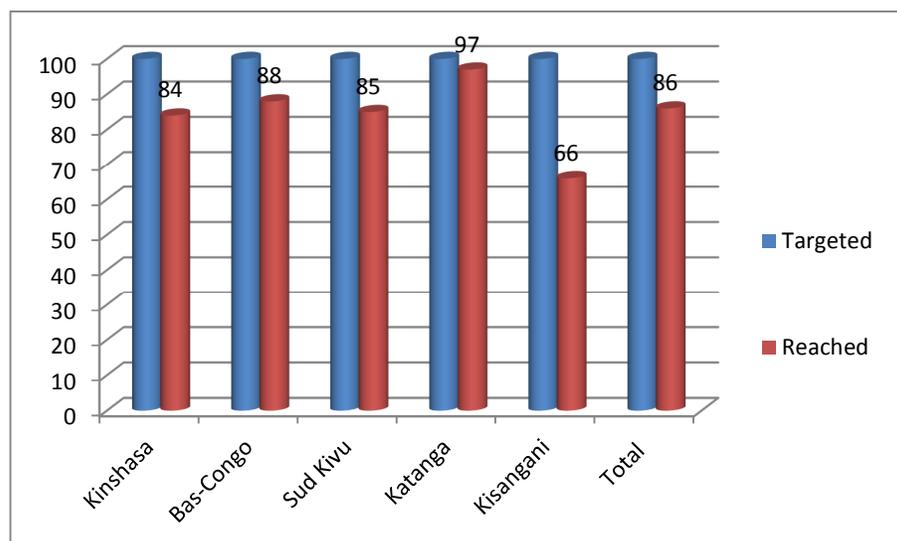
During Year 3, the PMTCT component focused efforts on improving the quality of PICT in all PMTCT sites. Figure 9 shows how PICT at the time of labor and delivery enables reaching women who did not come for antenatal care services. In fact, 10 percent of pregnant women were reached at the time of labor and delivery.

Figure 9. Pregnant women tested according to the PICT strategy, per province, October 2011 to September 2012.



Seroprevalance rates for pregnant women in ProVIC-supported sites ranged from 0.9 percent to 4.8 percent. ProVIC found the following rates in Year 3: Bas-Congo 1.8 percent; Katanga 3.7 percent; Kinshasa 2.1 percent; Kisangani 4.8 percent; and Sud Kivu 0.7 percent. Figure 10 shows that 81.5 percent of HIV-positive women received ARVs for PMTCT in Year 3. The gap between the targets and achievements is explained by the fact that known HIV-positive women were not supported in ProVIC sites because they were on ARVs obtained through other programs. In Kisangani, new providers do not yet have control of HIV-positive women.

Figure 10. Proportion of HIV-positive women who received ARVs to reduce the risk of mother-to-child transmission, by province.



In Year 3, 39 percent of HIV-positive pregnant women received ART, and 60 percent received zidovudine, according to the PMTCT national protocol.

Figure 11 below illustrates that of the 16 sites offering PMTCT services in the third quarter of Year 3, 100 percent of women attending antenatal care were counseled and tested for HIV. Numbers of pregnant women attending antenatal care exceeded the target, likely due to increased awareness on the part of community agents working through the champion communities, demonstrating the positive impact of well-integrated activities. In addition, the use of PICT at antenatal care and at the time of labor and delivery has resulted in a higher number of women counseled and tested, exceeding the number of pregnant women arriving at antenatal care because women who came in just for labor and delivery also received counseling and testing. This shows the success of ProVIC's PICT model.

Table 4. PMTCT activities in the third quarter of Year 3.

Activities	Targeted	Reached
Pregnant women in ANC	7,270	7,376
Pregnant women counseled	7,270	8,139
Pregnant women tested	7,270	7,951
HIV-positive pregnant women	145	130
HIV-positive women on ARVs	140	130
Exposed infants on ARVs	140	65
EID within two months	140	89
Exposed infants on CTX at 6 weeks	89	68
Counseled male partners	1,628	501
HIV-tested male partners	1,628	495

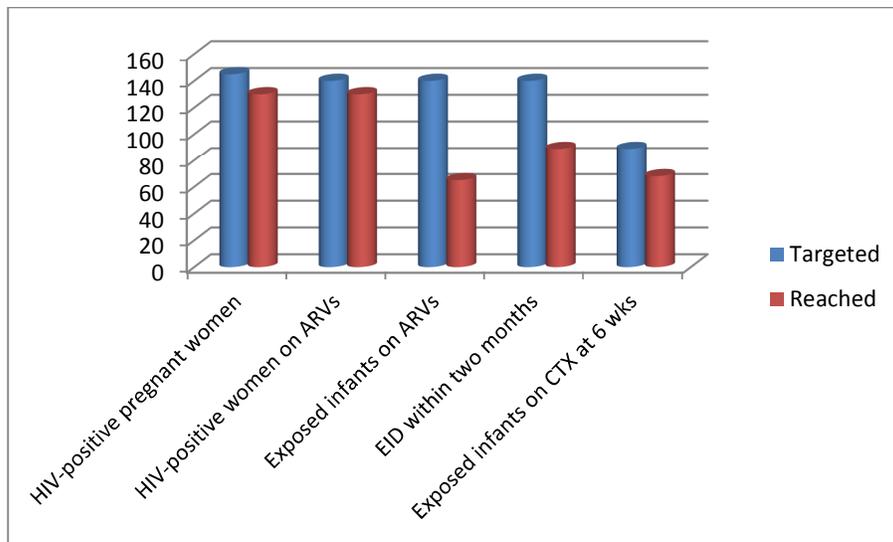
ANC: antenatal care.

In contrast, the number of male partners tested remains very weak (less than 5 percent of targets). The project is testing several mechanisms for increasing male partner involvement in PMTCT, including issuing written invitations in local languages to women to invite their partners to family health services sites; working with sites to extend service hours to later in the evening and on weekends to allow working men to visit; and working to improve the reception for male partners at PMTCT sites. Men who do present for an HIV test and who test positive are referred to HIV care facilities for care and treatment.

Figure 11 below shows that of the 460 pregnant women who tested HIV positive in the third quarter of Year 3, 96 percent received ARV prophylaxis or ART according to the national protocol for PMTCT. The weakness here in ProVIC’s PMTCT cascade is seen in the low rate of HIV-positive women returning to deliver at the maternity. This is a problem nationally, not just at ProVIC sites. At ProVIC sites in Year 3, the rate of return for delivery was 53 percent.

This same weakness results in the loss of HIV-exposed infants. ProVIC is making an effort to recover as many of these infants as possible through young child visits at 6 weeks, using tools which have been developed for tracking mother-baby pairs, phone calls, and home visits by providers when clients miss expected appointments.

Figure 11. Analysis of the PMTCT cascade of activities in the third quarter of Year 3.



Activity 5. Improve access to comprehensive PMTCT services

During Year 3, the PMTCT Specialist provided technical assistance to providers to reinforce the linkages between PMTCT activities, family planning, and other maternal and child health services. Where family planning services were not yet implemented, providers were encouraged to offer referrals for pregnant women as needed. Providers at Catholic facilities were encouraged to refer clients to the closest facility with available family planning services. Currently available family planning commodities include condoms, intrauterine devices, injectables, and contraceptive pills. Providers were trained on family planning in May 2012, in anticipation of the distribution of contraceptive supplies to all ProVIC PMTCT sites across DRC.

As part of ProVIC’s mission to support the health of mothers and their infants, in Year 3, the project team developed strategies to decrease fees for HIV-positive pregnant women visiting PMTCT sites. ProVIC was able to reduce delivery fees for HIV-positive pregnant women as part of its PMTCT Acceleration plan. This strategy, which will be managed by ProVIC-supported health facilities under their fixed-obligation grants, is expected to encourage HIV-positive pregnant women to return to the same maternity ward where they received antenatal and PMTCT services to deliver their babies—thereby increasing their chance of completing the full range of services under the PMTCT cascade and reducing the chance of mother-to-child transmission.



Mother and her twins, Mvuzi Health Reference Center

During supportive supervision visits to project-supported PMTCT sites, ProVIC’s PMTCT, Senior Pediatric, and Provincial Prevention Specialists provided technical assistance to providers to reinforce the linkages between PMTCT activities, family planning, and other maternal and child health services.

In November 2011, ProVIC’s Senior Pediatric Specialist, Dr. Mitterrand Katabuka, traveled to Addis Ababa, Ethiopia, to participate in the PEPFAR “Technical Working Group for Care and Support, PMTCT/Pediatrics, OVC, and Food and Nutrition Driven Learning,” meeting hosted by the US government and partners in Africa. The purpose of the three-day meeting was to share promising practices and approaches to integrating HIV prevention, treatment, care, and support services for pregnant women and infants and their mothers.

In September 2012, PMTCT Specialist Dr. Berthe Banzua traveled to Nairobi and Kisumu, Kenya, for a learning exchange on the Mentor Mother model, which will be piloted by ProVIC in Year 4. The approach is designed to improve the retention of HIV-positive women in the PMTCT program by using specially trained PLWHA peer educators who have themselves already been through, and understand, the PMTCT process. This approach is also intended to improve the rates of male partner involvement and follow-up of mother-infant pairs.

Sub-IR 1.4: Community- and facility-based GBV prevention and response services strengthened

Activities and achievements

This report covers the six-month period from April through September 2012, including the start-up phase of the integration of GBV activities in various ProVIC technical areas. ProVIC is implementing GBV activities at the community level through champion communities in Kinshasa and Kisangani, and through eight PMTCT sites in the same provinces where key

staff are being trained to screen clients for GBV, and provide GBV survivors with immediate medical care and psychosocial support, as well as referrals for additional services. The eight health structures where ProVIC is integrating GBV-related services at PMTCT sites are in Kinshasa (HGR Mbankana/ZS Maluku II, CH Kikimi/ZS Kikimi, CH Kingasani/ZS Kingasani, CS Binza Weather/CS and ZS Binza Libondi/ZS Bumbu), Kisangani (CS Malkia/ZS Tshopo Nehema CS/ZS Makiso and HGR Kabondo/ZS Kabondo).

From May 1 through May 11, 2012, the GBV Specialist and other ProVIC colleagues undertook a field visit to Kisangani. This allowed the visitors a first-hand look at the realities surrounding the battle against GBV and HIV, and has helped ProVIC to ensure that the GBV interventions are aligned with identified needs and gaps. This in turn has helped ProVIC to initiate an appropriate response to demands and needs, and to identify indicators to be attained in FY12. The visit involved meetings with government partners, international NGOs, United Nations organizations, local NGO health facility staff, and community members. The team selected three health facilities for the support of SGBV survivors in three ProVIC intervention zones.

The ProVIC GBV Specialist and PATH Gender and GBV Researcher initiated the integration of GBV into ongoing HIV activities by holding an orientation workshop on July 6 for ProVIC staff and other US government partners and key stakeholders on gender-related concepts, attitudes toward gender and GBV, and the links between HIV and GBV. Seventeen participants took part in the orientation, including 12 ProVIC staff and one representative each from USAID, the PNMLS, the PNL, PROSANI, and C-Change. Following this, the ProVIC GBV Specialist and PATH Gender and GBV Researcher drafted a work plan for the remainder of Year 3 and Year 4, and held a planning workshop to gather input from other ProVIC technical heads, as well as the Kinshasa Provincial Coordinator and a representative from the *Ministère des Affaires Sociales* (MINAS). The following subsections highlight key activities and achievements as outlined in the work plan. At this time, ProVIC has made considerable advancements, particularly under PEPFAR indicator P12.5D: Number of people reached with an individual, small group, or community-level intervention or service that explicitly addresses GBV. In the third quarter of Year 3, ProVIC reached 959 females and 576 males. In the fourth quarter of Year 3, this increased significantly, and at year-end, a total of 14,922 individuals had been reached (7,402 females and 5,667 males)..

Activity 1. Strengthen the capacity of Champion Community members and NGOs to undertake community sensitization on gender and SGBV

The ProVIC GBV Specialist has been in direct and regular contact with key staff within the PNSR to discuss ProVIC's approach to capacity-building at the community level, and sought collaboration of PNSR colleagues in the planning of a five-day training (July 17–21, 2012) for 76 Champion Community members and NGO staff working in Kinshasa Province communities, and the same five-day training (August 28–September 3, 2012) for 80 participants in Kisangani Province communities. The Kisangani training was coordinated with other ProVIC Champion Community HIV training activities, and family planning was also integrated into the training. Champion Community members selected for the workshop included steering committee members, as well as community members responsible for various community network activities and peer educators. According to ProVIC's selection criteria, training participants were required to be living in a ProVIC-supported Champion Community, have had previous training on the Champion Community approach to addressing HIV, have demonstrated engagement and enthusiasm for advancing Champion Community

activities, have an interest in promoting gender equality, and be willing and able to put into practice the concepts learned at the workshop. Both trainings were facilitated by PNSR-trained facilitators, with active participation of the GBV Specialist, using the PNSR curriculum *Module de Formation des Relais Communautaires et Pairs Educateurs sur les Violences Sexuelles et Base es sur le Genre*. Separate reports for the trainings in both Kinshasa and Kisangani are available.

Activity 2. In collaboration with other ProVIC technical departments, develop the “Champion Men” (“Champion Women”) approach to be implemented within champion communities

ProVIC continues to work to develop this activity. Technical program staff from PATH’s Washington, DC, office have drafted a strategy and ProVIC’s GBV Specialist and PATH Program Associate have organized a technical meeting to gather input on the proposed design from other ProVIC technical heads, as well as discussions with several Champion Community Steering Committees. The strategy will be further developed and launched in the first quarter of Year 4.

Activity 3. Develop/Adapt a GBV screening tool to identify individuals at health facilities who may require services

Through continuous communication with the PNSR, ProVIC understands that there are ongoing efforts to establish a national GBV screening tool, in collaboration with the Kinshasa School of Public Health and the University of North Carolina. While this format has not yet been formally adopted, PATH technical staff in Washington, DC, have also investigated other possible models to identify any possible adaptations. PATH has met with Dr. Nancy Glass at the Johns Hopkins University School of Nursing to discuss work in the eastern DRC, including use of screening tools that their program has developed. In coordination with the PNSR, the ProVIC GBV Specialist has shared the draft national GBV screening tool at a training of health care providers, in order to alert health care professionals that they will be asked to screen clients for GBV. Although the screening tool has not yet been formally adopted, the health care providers with whom ProVIC works to provide GBV services are now familiar with the tool.

Activity 4. Strengthen capacities of health workers at PMTCT sites on GBV screening, medical care, and referral of GBV survivors to additional services as needed

During the last two quarters of FY12, the GBV Specialist was in direct and regular communication with the PNSR to schedule a training for health care providers on the medical management of SGBV cases. For much of this period, the PNSR was in the process of finalizing the training curriculum, which caused slight postponement of the training until October 9–13, 2012. The ProVIC GBV Specialist and Pediatric Specialist participated in a TOT program hosted by the Center for HIV/AIDS Strategic Information/CDC in collaboration with the PNSR August 20–25, 2012. All participants from that training, including the two ProVIC staff who attended, are certified to lead trainings of health care providers using the PNSR training curriculum *Module de Formation des Prestataires des Soins de Santedans la Prise en Charge des Survivants/Victimes des Violences Sexuelles et Baséessur le Genre*. ProVIC scheduled the five-day training, which took place in Kinshasa, as soon as possible after the training curriculum was approved and schedules could be coordinated with the PNSR trainers. Topics included the causes and conceptual basis of GBV, the links between HIV and GBV, GBV screening, clinical examination of sexual violence cases, preventive and curative treatment of STIs, administration of post-exposure prophylaxis for the prevention of HIV infection, and collaboration with community actors

and other sectors involved in GBV prevention and response. Twenty-one health care providers participated in the training, including doctors, PMTCT counselors, midwives, and nurses from five health zones (Binza Météo, Bumbu, Kikimi, Kingasani, and Maluku). The same training for health care providers at selected PMTCT sites in Kisangani will be held November 19–23, 2012.

Activity 5. Develop/Adapt data collection forms to document GBV cases and care provided at health facilities

ProVIC has obtained a copy of the *Dossier Medical du Survivant/Victime de Violence Sexuelles* developed by PNSR and adopted by the MOH. This is a comprehensive document validated earlier this year and oriented toward sexual violence cases specifically. This tool does not need specific adaptations at this time. In the coming year, however, ProVIC will assess the extent to which it is currently used in the eight health centers where the project supports GBV services, and identify any gaps in implementation. We will also examine the extent to which other forms of GBV (i.e., other than sexual violence) are documented, and work with the PNSR and local health services to address any gaps in the availability and/or use of these GBV documentation systems. Proper documentation of sexual violence cases, on the basis of this document, was included in the training of health care providers noted above, and ProVIC is ensuring that the forms are available at each of the PMTCT sites where GBV activities are integrated.

Activity 6. Strengthen referral and counter-referral systems for the holistic management of GBV care in selected communities

As part of the integration between different areas of intervention within ProVIC, and in consultation with USAID, a decision has been made to shift all activities related to referral and counter-referral under the HSS activities within ProVIC. As GBV-related counseling and medical care is integrated into PMTCT services at the eight health units designated for GBV services, the GBV Specialist on the ground will closely monitor the use of referral and counter-referral systems for GBV, with special consideration for the confidentiality of information related to GBV cases, and to ensure that individuals experiencing GBV benefit from holistic care according to their needs. This topic was covered during the training of health care providers described above. As this system increasingly integrates GBV cases, ProVIC will also coordinate with other actors on the ground to ensure availability of services and appropriate follow-up of cases referred.

Intermediate Result 2: Care, support, and treatment for people living with HIV/AIDS and orphans and vulnerable children improved in target areas

Overview/Summary

ProVIC's overarching vision is to create a community-wide response to supporting PLWHA and their families, so communities can address their own care and support needs and mitigate the impact of HIV while reducing dependence on the project. Our key strategy has been to build community resilience and sustainability.

ProVIC's Care and Support structure is based on three cornerstones: self-help groups, C2C groups, and home visits. Four methodological approaches underpin the work: (1) the family-centered approach recommended by PEPFAR; (2) Positive Health, Dignity and Prevention (PHDP) concepts; (3) palliative care; and (4) the methodology of the self-help and C2C groups.

Throughout the year, PLWHA benefited from ProVIC's Champion Community approach to transforming communities and their responses. Awareness-raising on stigma and discrimination, as well as the needs of PLWHA and their families, stimulated the community to improve the links between care and support and other community health services. The implementing partners coordinated the involvement of the community volunteers and the Champion Community Steering Committee and together these community structures assisted people in accessing services through referrals, accompaniment, and, at times, by advocating on their behalf. Through the structure of community volunteers, ProVIC supported 8,500 home visits to PLWHA and their families across the 40 champion communities.

ProVIC has improved the linkages between community-based structures (self-help groups, C2C groups, home-based care, and the Champion Community Steering Committees). ProVIC's broader strategy has also improved the quality of and linkages to technical services in health structures within the health zone. This work is ensuring continuity of care and improved access to a broad range of services related to HIV/AIDS and to preventative and curative health care.

Through the activities listed below, ProVIC's Care and Support component reached 15,560 PLWHA and OVC in Year 3, increased the number of PLWHA self-help groups from 149 to 196, and more than doubled the number of C2C groups for OVC from 93 to 193.

Sub-IR 2.1: Care and support for PLWHA strengthened

Activities and achievements

Activity 1. Strengthen capacity and ensure the quality of palliative care and management of malnutrition in PLWHA

ProVIC collaborated with Heal Africa to develop a palliative care guide, which includes a checklist for home visits, a health questionnaire for PLWHA, and a palliative care kit (comprised of a home care kit and a malnutrition diagnostic kit). ProVIC also supported *Programme National Intégré d'Alimentation et de Nutrition* (PRONANUT) in finishing the national protocol for nutritional care of PLWHA, which had been on hold for several years, and a simplified guide to managing malnutrition in the form of briefing notes based on the national protocol. An international consultant trained the Care and Support team, as well as four provisional nutritionists nominated by PRONANUT, on the new protocol. The nutritional tools were validated with the government before proceeding to train caregivers in their use.

The palliative care guide

The palliative care guide, produced in May 2012, draws on WHO and PEPFAR recommendations on palliative care and on African Association of Palliative Care guidance. The aim was to produce a practical guide to ensure the quality of home-based care for PLWHA suffering from pain and other symptoms associated with AIDS. The palliative care guide includes a questionnaire to review the health of PLWHA, a guide on the use of the palliative care kit, and a checklist for home visits. Together, these ensure consistent quality of care. In addition, 420 palliative care kits have been distributed to the 14 grantees. The use of the kits is managed by the grantees' social workers and caregivers who support the self-help groups.

Finalization of the national protocol on nutritional support for PLWHA and production of advice sheets on the management of malnutrition among PLWHA

Following a request from the Food and Nutrition Technical Assistance (FANTA) Project, ProVIC updated the 2006-2007 draft national protocol on nutritional support for PLWHA. A participatory process guaranteed buy-in from 40 stakeholders in government bodies, including PRONANUT and PROSANI, and led to the document's validation. Prior to this, DRC lacked a set of best practice standards to guide both the health system and nongovernmental agencies on how to assess the nutritional needs of PLWHA, identify cases for referral, and provide guidance on the type of nutritional support and advice needed to address moderate and acute malnutrition.

Based on this protocol, ProVIC produced a simple nutritional guide to be used by self-help groups and during in-home visits by caregivers, social support workers, care providers, and volunteers. The guide, which is accompanied by 19 job aids on nutrition for PLWHA, will build the capacity of community actors to identify serious or moderate malnutrition in PLWHA in order to provide appropriate referral. For cases of slight malnutrition, these tools provide examples of appropriate food combinations and amounts required to prepare balanced meals for the health of PLWHA.

Training of caregivers

Our objective was to train caregivers in palliative care and rapid evaluation of nutritional status and in the management of malnutrition among PLWHA. Caregivers are community volunteers (care providers and community health agents) within champion communities who are organized by grantees to work with PLWHA and their families through the self-help groups, C2C groups, and home visits. Caregivers are pivotal in assessing the care needs of PLWHA. In Year 2, caregivers were trained on palliative care. In Year 3, 20 trainers in Bas-Congo were given further training based on the updated palliative care guide and the new PLWHA nutritional protocol. Training organized at PMTCT sites highlighted the importance of the integration of ProVIC care and community support activities with existing health structures, as recommended by USAID.

In partnership with PRONANUT and the PNLs in Bas-Congo, 20 caregivers were trained on:

- Improving prevention and nutritional management of PLWHA, taking into account the interactions between nutrition and HIV, nutritional evaluation, program options to support nutrition, and nutritional care of adults, women, and children living with HIV/AIDS.
- Key messages to provide beneficiaries with effective ways to prevent malnutrition.
- Management of symptoms such as pain, fatigue, dyspnea, nausea and vomiting, and persistent diarrhea.
- Information on community care, home-based care, examining patients at home, managing adherence, managing biomedical waste, and follow-up.
- Maintaining medical and social work files.
- Referral pathways for severe cases.
- Mapping of Nutritional Intensive Treatment Units (UNTIs) and Mobile Nutritional Treatment Units (UNTAs).
- Theory on how malnutrition is managed in a clinical setting, accompanied by practical exercises at HRG Kiamvu led by PRONANUT Bas-Congo.

Provision of home visits and external referrals to those in need

More than 8,000 PLWHA received regular home visits by social workers, caregivers, and volunteers. Self-help groups decide which members need home visits based on who is chronically absent or a particular vulnerability. A checklist has been developed to ensure visits are systematic and properly documented.

Activity 2. Provide cotrimoxazole (CTX) to PLWHA and ensure long-term access

During Year 3, 6,144 of PLWHA received CTX directly from ProVIC: 1,150 in Bas-Congo, 1,291 in Katanga, 2,629 in Kinshasa, and

1,074 in Sud Kivu. Seventy-one percent of PLWHA who received CTX were women, which is consistent with the feminization of the epidemic. ProVIC's target was to provide CTX to 75 percent of all PLWHA. ProVIC's criteria are more stringent than the government's guidelines (which recommend that 100 percent of PLWHA receive CTX regardless of the stage of their illness), leading to fewer people being selected for receipt of the drug by this project. In Year 4, ProVIC will align its policy to the national standards and target 100 percent of PLWHA with CTX. In light of USAID's preference that the provision of CTX be provided within health settings, the Home-Based and Palliative Care Specialist will work with grantees and the health zones to consider how to make CTX more readily available from government facilities.



Caregivers training, Matadi, September 2012

The project's clinical services supported 6,482 PLWHA, 74 percent of our target. As the C2C groups expanded and shared more information about available services, more children benefited—1,702 children younger than 15 years (1,162 of whom were girls) received services. This increased uptake will require ProVIC to seek further opportunities to expand services to children.

ProVIC's TB screening activities were ongoing in self-help groups and will be further expanded in our integrated health facilities. In Year 3, however, we misunderstood the TB screening indicator as a treatment indicator, and, as a result, did not measure the number of beneficiaries screened for TB. Although TB screening is routine in self-help groups, ProVIC has not yet introduced the nationally agreed new TB checklist, as it has yet to be validated by the government. However, 397 beneficiaries were placed on TB treatment in ProVIC-supported sites, which are also TB diagnostic sites. This number was very low due to long stockouts of TB diagnostic tools and medications in several of the provinces and zones where ProVIC works. ProVIC will work more closely with the TO2015 project in FY13 to improve on the data collection and monitoring tools and improve on the results.

Activity 3. Provide nutritional assessment, counseling, and support and supplementary food through self-help groups, C2C groups, home visits, and medical settings

Nutritional assessment, counseling, and support is a comprehensive sector-wide approach to improving nutritional status. It links policies, programs, and health services around nutrition and involves building the capacity of community-based and health structures to conduct systematic assessments and offer nutritional counseling and support to those most in need. It was not yet possible to systematically introduce this approach in Year 3, as grantees and community volunteers working with the self-help groups needed to follow agreed-upon national standards, and the guidance was still under discussion with national stakeholders and in the process of being validated and adopted. ProVIC was also limited in terms of the budget available for nutritional support. That said, self-help and C2C groups did manage to cover three of the recommended components: guidance on water purification, nutritional counseling and diagnosis, and referral of PLWHA with malnutrition. The guidelines were introduced by the beginning of the fourth quarter, and the approach will be promoted in Year 4 within the clinical and community domains.

The new guidance on water purification recommends demonstrating different methods. In Sud Kivu, the implementing partner, Bakongo, obtained Aquatabs from PSI for self-help group members. Other groups discussed boiling and filtering water as ways to improve water quality.

As a result of the new guidance, nutritionists from the grantees and the health zones identified 990 of the expected 1,301 PLWHA (76 percent) with acute, severe, or moderate malnutrition using anthropometric measures (weight, waist measurement, arm circumference)

and clinical evaluation, who were subsequently referred to UNTIs or UNTAs to obtain Plumpy'nut. ProVIC reached 6,202 people with nutritional support services, including nutritional counseling and demonstration of the nutritional value of locally available foods. Women made up 61 percent of those who received nutrition counseling services. An analysis of those most affected by malnutrition found that more young people, women, and the unemployed are affected.

The self-help and C2C groups also organized community meals to enhance group dynamics. These meals were followed by nutritional counseling of PLWHA and OVC to promote understanding of the importance of certain local products in improving health and food preparation techniques that avoid the loss of nutritional value. These community meals not only strengthened links between PLWHA but also contributed to improving their nutritional status.

Government guidelines recommend that ProVIC refer PLWHA for treatment when they identify acute malnutrition, thus removing responsibility for care at this point. However, after



Manioc harvest in a community field intended for sale and to feed PLHIV members of the Mbimbi self-help group in Kinzau Vuete, Bas-Congo

a stay in the hospital, PLWHA return to the community, and if the underlying causes which led to their malnutrition have not been addressed, they may relapse. In Year 4, the partnership with the Food and Agriculture Organization of the United Nations (FAO) will introduce a food security program for PLWHA and OVC to address this issue.

Activity 4. Partner with FAO

ProVIC is now only expected to receive approval of this memorandum of understanding (MOU) in FY13, so the activity did not take place in FY12.

Activity 5. Finalize key messages for PLWHA groups on PHDP

ProVIC worked toward providing self-help groups with a set of discussion materials that promote the PHDP concepts, based on four themes: taking care of ourselves, protecting ourselves, staying in good health, and getting help. These materials—an image for each subtopic with key messages—will facilitate group discussions around important issues that promote behavior change. The tools will give groups a means of reviewing regularly what individuals need to do to help themselves. The materials, as well as the skills to facilitate discussions, will lead to group sustainability and autonomy over time.

ProVIC is collaborating on these materials with C-Change, which is mandated to support the communications activities of USAID partners funded by PEPFAR. ProVIC and C-Change organized a two-day workshop and trained 22 ProVIC staff and partners to hold focus group discussions on the four themes and collate the data they gathered on knowledge, attitudes, and behaviors of PLWHA in order to develop the key messages. Participants have organized the focus group discussions, but have yet to meet and produce the final key messages and educational materials. This will be organized early in Year 4.

Activity 6. Organize regular self-help group meetings to address problems and discuss PHDP

Self-help groups are an important mechanism for PLWHA to meet together and mobilize to address issues that are most pertinent to their members. They offer a safe place to discuss issues faced by members and the wider community, including health and social problems. They aim to improve treatment adherence, provide psychological and spiritual support, and increase solidarity and a sense of community among PLWHA. They also seek to reduce negative perceptions of HIV/AIDS in the wider community. The groups remain a key cornerstone to ProVIC's Care and Support work, alongside C2C groups and home visits.

The number of self-help groups increased from 149 in Year 2 to 196 in Year 3, and 14,197 PLWHA and children (75 percent of those reached) regularly took part. Grantees worked with community volunteers to establish or re-establish the groups, particularly through referrals from PMTCT sites and health facilities. The increase in both reach and number of groups demonstrates the benefit that members feel these activities bring to their lives. Self-help groups consist of about 25 members who meet on a monthly basis. Each group is guided by internal rules and the roles and responsibilities of members, including that of the president and secretary who are nominated by the groups. The groups are supported by an animator, usually a grantee volunteer. Meetings follow a monthly program of themes, which brings about greater consistency between self-help groups, harmonization of interventions and messages, and closer links to health zones.

A range of topics and activities are addressed during meetings, including:

- Psychological and spiritual support by peers, which improves the well-being of members.
- Advice and discussion on issues such as positive living, gender and HIV, ethics, positive prevention, sexual health and risky behaviors, partner disclosure, reproductive health, confidentiality, treatment adherence, and risks associated with drugs and alcohol.
- Advice on human rights for PLWHA and the laws protecting them by representatives from rights organizations.
- Support to implement income-generating activities (IGAs) to increase income sustainability.
- Referral for HIV testing, family planning, and nutritional, medical, and legal support.
- Sign-posting to palliative care services and emphasis on the importance of home visits, home-based care, and clinical care (referral and counter-referral).
- Sign-posting and referral to PMTCT services and TB screening.
- Nutritional education, cooking demonstrations, malnutrition diagnosis, and distribution of nutritional kits of locally sourced foods.
- Guidance on hygiene (personal, clothing, environmental).
- CTX prophylaxis.

The self-help groups are proving extremely effective in reducing self-stigma and self-discrimination and promoting confidence in individuals. Effective key messages stimulate group discussions that build a sense of agency and strengthen self-esteem; this, in turn, helps PLWHA adopt behavior change recommendations and leads to improved health outcomes. The groups have revitalized solidarity among PLWHA, strengthened peer support, and enabled people to come out into the open about their status. Meetings encourage members to take control and seek solutions to their common problems. Various groups have allocated funds for social activities among themselves, while others have set up solidarity funds which they manage themselves. This is a sign of the groups' increasing autonomy.

Members of self-help groups often describe dramatic improvements in their psychological well-being and treatment adherence, as well as financial situations and diets, through participation in savings schemes/solidarity funds and IGAs. This, in turn, has a profound impact on their social situations, as they experience greater acceptance by their families and integration into wider society. This helps to explain the spectacular growth in self-help groups.

Thanks to the self-help groups, in Year 3:

- 13,358 people were provided with psychosocial and spiritual support.
- 15,560 people received at least one care service.
- 6,482 received at least one clinical service.
- 6,202 received food/nutritional counseling.
- 1,006 received therapeutic nutritional support.
- 397 were screened, referred, and started on TB treatment.

Activity 7. Provide quality assurance of self-help group meetings and activities

ProVIC has developed a concept paper on quality assurance of self-help group meetings and C2C meetings, including fundamental ideas on autonomy, and shared it with implementing partners. The Care and Support Managers have been instructed to participate on a regular basis in meetings held by these groups and to monitor the quality of the messages given by the animators. With the new health zone strategy, mentoring will take place between these groups, health centers, and the HGRs. This will lead to increased knowledge of STIs, ARVs, opportunistic infections, positive health, and CTX, and will also facilitate access to care for PLWHA and OVC. Quality assurance will be strengthened in Year 4 with the training of animators on the key messages and the new C2C manual and with the systematization of coaching and mentoring of the groups.

Activity 8. Provide training on the village savings and loan association approach

This activity was added into the Year 3 work plan following USAID recommendations, as it contributes to ProVIC's mandate to mitigate the impact of HIV through provision of economic strengthening. The introduction of village savings and loan associations (VSLAs) is intended to increase financial autonomy within the champion communities and self-help groups. With technical support from the Livelihood and Food Security Technical Assistance (LIFT) Project, ProVIC trained its Care and Support team, Community Mobilization team, and staff from the grantees on the VSLA approach. Twenty participants from five provinces and from the national level took part in this training in September 2012. The approach will help champion communities become autonomous and continue to implement activities in the fight against HIV/AIDS when donor funding is no longer available. It will build the organizational and economic capacity of self-help group members to seek solutions within their communities in response to economic instability. Planning for this approach is underway and will be piloted early in Year 4.

Activity 9. Provide support for IGAs for improved quality of life

In response to the aspiration of PLWHA to have greater financial stability, ProVIC grantees have been supporting self-help group members with economic strengthening activities. In Year 3, a total of 741 eligible adults and children benefited from microcredit, training in conducting IGAs, and/or training in how to manage IGAs, exceeding the target of helping 440 individuals.

Market research on IGAs was carried out by grantee social workers, who supported groups to select members who would benefit from the activities. The selected members received microcredit loans, repayable with interest, in order to benefit more people in the group. Each received some training before starting their chosen activity. The IGAs were monitored and evaluated periodically by members of the Champion Community Steering Committees as well as grantees, in order to measure success and find rapid solutions when there were risks of failure. In Kinshasa and Bas-Congo, ProVIC's Home-Based and Palliative Care Specialist and Senior Grants Manager provided quality assurance by reviewing this work with the partners.

Several categories of IGAs have been funded, ranging from small commerce to livestock rearing, agriculture, and fish farming. A few examples include:

- The purchase of 100 chairs, ten plastic tables, a generator, and a tent for funeral services in Mafuta Kizola in Kinshasa, with support from *Réseau National d'Organisations Assises Communautaire* (RNOAC).

- Sewing recycled rice sacks to produce school bags, handbags, and table linen for sale in the champion communities of Biyela and Kikimi in Kinshasa, with support from the Society for Women and AIDS in Africa.
- A mill and community garden for growing manioc in Sud Kivu, with support from *Association de Lutte pour la Défense des Droits de la Femme et de l'Enfant*.
- The sale of sweet drinks, flour, bread, and animal feed, and the establishment of a beauty salon, with support from JADISIDA and CEMAKI.



Bean field run by PLWHA members of the self-help group Joy in Seke Banza; harvested beans and groundnuts

Income-generating activities have produced spectacular results. They have given hope to PLWHA and allowed them to be re-integrated into their families and their communities. In addition, the activities have stimulated community support from both the groups and the broader community. The following are some examples of this:

- In the Champion Community of Kinkenda in Kinshasa, a woman living with HIV was isolated by her family after her husband died. She and her children became homeless, and her health rapidly deteriorated. The self-help group members found her and brought her to the group. She received care and obtained microcredit, thanks to her peers who had paid into the solidarity fund, which she used to buy cola nuts to sell. Eventually, she was able to rent a house and is now able to buy food for her children. She is planning to send the children back to school once she has purchased the school kit.
- In Sud Kivu, IGAs have strengthened the links between beneficiaries and Champion Community Steering Committees. The Kimanga committee has used proceeds from poultry farming and soap-making to provide nutrition and hygiene kits to PLWHA and OVC.
- In Kabimba Champion Community, self-help group members are entitled to a portion of the flour from the community flour mill installed by ProVIC last year and the harvest from the community garden. In this way, PLWHA and OVC have become less dependent on the program.
- A young woman in Kinkenda in Kinshasa, who had been rejected by family members after the death of her father from HIV/AIDS, has been able to obtain her diploma. She hopes to go to university, thanks to savings generated from the IGA she embarked on after receiving training from the grantee.

Sub-IR 2.2: Care and support for OVC strengthened

Activities and achievements

Activity 1. Organize C2C meetings using the child-to-child methodology

In Year 2, ProVIC introduced the C2C approach as one of the three cornerstones of the Care and Support component. This approach encourages children and young people to play an active role in the promotion of their own health and well-being, as well as that of other children, their families, and their communities. It helps them to increase their skills, confidence, and self-esteem and to work together to increase solidarity within the group. This, in turn, increases children's resilience and ability to deal with the difficulties in their lives. The methodology relies on a participatory process to develop children's problem-solving abilities so they become agents of change, introducing ideas to their families and other children in the community.

In Year 3, the number of C2C groups increased from 93 to 193. Children in the groups have access to psychosocial support and benefit from a range of learning techniques, including drama, role play, games, songs, and drawings. Role plays are used to demonstrate the collaboration between donors, local and international NGOs, and the community in the fight against HIV/AIDS and the promotion of development.

With the help of a consultant, ProVIC updated the C2C manual, adapting it to the DRC context and building in quality assurance. The consultant adjusted the approach and developed activities in consultation with key informants, including children, C2C group animators, pastors, teachers, tutors, grantees, and members of OVC national coordination groups. A facilitator's guide was produced to assist with the training. The consultant trained seven champion trainers who will go on to train their peers and animators. Budget constraints delayed this training, and it will now take place in Year 4.

The positive impacts of the C2C groups can be seen at several levels:

- Children have acquired a good knowledge of HIV and modes of transmission, prevention of infection, health promotion, hygiene, and combating waterborne diseases. They are increasingly able to reflect on their problems and propose possible solutions.
- Children are more confident in discussing challenging issues with their living parent or guardian; for example, broaching the subject of reducing alcohol consumption in order to be able to pay for school fees. Girls who have experienced physical and sexual abuse now have the courage to talk about their abuse, and, in some cases, the guilty parties have been arrested and punished. Sometimes children ask the animators to raise difficult subjects for them, such as discussing the importance of condom use when a parent is being unfaithful to their partner.
- Parents notice dramatic improvements in the behavior of children who participate in groups. These children are less likely to join gangs, are better students, and develop better relationships based on mutual respect with members of the wider community. They are also beginning to prepare more for their future and protect themselves from HIV/AIDS.
- C2C group animators have noticed a reduction in children's stress levels as the program helps them to forget some of their worries.
- Animators have also developed their capacity as a result of the training on C2C group facilitation, which has improved their expertise in supporting groups and communicating

with children. They now feel better able to address topics with young people of different ages, and they encourage children to take a greater lead in discussions.

- There is much greater acceptance and enthusiasm among parents who initially had been skeptical of the groups, thanks to the observed behavior change in children. Parents and community members have encouraged children to attend, and, as a result, children are coming to the groups in large numbers. The increased popularity of the groups means attendance is always high. There is also demand from the community for C2C groups to be introduced in schools, churches, and community centers.

With the success of the C2C groups in Year 3, animators, grantees, and the Care and Support team began putting measures in place to improve group sustainability. For example, animation skills are being transferred from animators to older children.

Activity 2. Provide the most vulnerable OVC with school fees

In DRC, one child in four is an OVC. According to the Rapid Assessment, Analysis, and Action Plan,¹ there were 8.2 million OVC in the country in 2009. While government policy dictates that primary schools not charge fees in order to guarantee universal access to primary education, this is not the reality. According to a United Nations Children’s Fund (UNICEF) report, “School fee practice is particularly aggressive and all invasive,” and “Households finance almost the entire cost of education.” Fees are a financial burden on poor households that bar children from accessing education.²

Recognizing that education is both a right and an important mechanism for helping OVC out of poverty and further vulnerability, ProVIC aims to support those who cannot afford an education. However, with a limited budget, it has been necessary to ration the payment of school fees. Grantees have been asked to select the most vulnerable OVC, particularly those who have lost two parents, live with a guardian suffering from chronic illness, or live in conditions that make it difficult to pay school fees or other costs of schooling. These criteria have helped to reduce discrimination and subjectivity.

In Year 3, 1,542 OVC (154 percent of the 1,000 expected) received school fee support or vocational training. These results were made possible by the application of PEPFAR guidance and the implementation strategies of block grants, social contracts, and investments in time. There were substantial differences among the provinces: 6 percent of all OVCs reached were in Bas-Congo; 37 percent in Katanga; 38 percent in Kinshasa; and 19 percent in Sud Kivu.

Block grants were implemented in provinces with high HIV prevalence, as recommended by PEPFAR guidance. Fifty-seven percent of the OVC who benefited from the block grant and were subsequently granted access to education were girls. This reflects the commitment of grantees to promote access to education for girls. Retention in the education system and progression to higher levels, as recommended by the PEPFAR guidance, was largely exceeded. In Year 4, strengthening participation of local education actors will create more ownership of the problem of education for OVC, especially girls, by champion communities.

¹ UNICEF, USAID, PNMLS. *Rapid Assessment, Analysis and Action Plan: Rapport Final de Synthesis 2009*.

² Verhaghe J. *School Fee Practice and Policy in DRC*. New York: UNICEF; 2007.

Activity 3. Promote social contracts and block grants to increase OVC access to school

Most grantees working on this activity have signed social contracts with schools: in return for a one-off investment, the schools have agreed to enroll OVC over the long term. This one-off investment has taken a variety of forms, including reconstruction of school walls, purchase of whiteboards, coverage of operating costs, and the purchase of books and supplies.

Combined with the payment of individual school fees (as described above), the block grants helped ProVIC surpass its target of supporting OVC with access to education and/or vocational training. In Year 4, the Care and Support team will monitor the block grant strategy and evaluate whether it should be used more widely in health zones with high prevalence, as recommended by PEPFAR.

Lobbying of business enterprises to make a philanthropic and financial contribution toward assisting the most vulnerable to gain access to education focused on CIELS and business leaders. This follows the successful lobbying of *Direction Générale des Douanes et Accises*, which contributed \$5,000, enabling 300 OVC to enroll in school in Year 3.

Activity 4. Provide ProVIC with an educational strategy

Plans to contract a consultant to develop an educational strategy were replaced with the recruitment of an HIV and OVC Specialist in September. This specialist will work with key actors within ProVIC and the government to develop an educational strategy that will increase coverage and sustainability. This strategy will link with the OVC program, in line with PEPFAR's recommendation to focus on girls' primary education and with the law requiring schools to provide free education to the most vulnerable OVC.

Activity 5. Provide ProVIC and its partners with child protection policies

In Year 3, ProVIC developed a child protection policy for its staff and volunteers. It articulates ProVIC's zero tolerance approach to child abuse and provides a framework for managing and reducing the risks of child abuse by persons engaged in delivering ProVIC activities. It was developed in collaboration with USAID's safeguarding initiative and the International HIV/AIDS Alliance's (IHAA) child protection policy.

ProVIC recognizes that partners have an equal duty to protect children in the program. In collaboration with human rights organization Africa Zone League for the Defense of the Rights of Children and Students, ProVIC supported the 14 grantees to develop organizational child protection policies. ProVIC has provided training in child protection issues for directors and/or board members of the grantees and assisted them in developing a template that could be adapted and adopted by each organization for presentation to their boards. In Year 4, ProVIC will follow up with grantees to ensure they have ratified and introduced this template or ProVIC's policy.

Child abuse is of particular concern in DRC, as levels are some of the highest in the world. UNICEF reports that 16,000 women were abused in 2008, 6 percent of whom were children. In light of ProVIC's mandate to provide legal protection, the Care and Support team piloted an approach for grantees to mainstream child protection into their programming by supporting or establishing community mechanisms to increase child protection. The key recommendation that emerged from the pilot was the importance of introducing an observatory/watchdog body that reports abuse to a central level.

Activity 6. Conduct advocacy campaigns on human rights issues/tackling stigma and discrimination in champion communities

The lack of capacity among grantees to address legal challenges facing PLWHA/OVC and their families led to ProVIC establishing partnerships with human rights organizations. In Kinshasa, ProVIC signed an MOU with *Centre Solidarité Nationale* (CSN), and grantees were trained by a legal advisor from the center allocated to each grantee to help to resolve human rights issues. Ninety-two PLWHA and OVC have benefited from juridical assistance through CSN, exceeding expectations. In Sud Kivu, partners collaborated with *Kivu Arche d'Alliance* and *Héritiers de la Justice*; in Bas-Congo, they partnered with *Association des Femmes Juristes*; and in Katanga, individual lawyers supported grantees.

These collaborations have led to the successful resolution of many cases, often related to land tax, inheritance disputes, discrimination, abuses of authority, and unjust dismissal.

Family mediation was also done to counter rejection by families. Eighty-two adults and children have been provided with protection and legal aid services, exceeding the Year 3 target of 35. In one case, an orphan who had been unjustly imprisoned for rape was freed with the assistance of a CSN advisor. In another, CSN's support led to the arrest of a soldier for the rape of a child that caused the girl to develop a fistula. PLWHA are beginning to feel more able to report abuses despite fear of discrimination in their communities and have greater confidence that the issues will be addressed.



Jadisida's OVC Sewing Learning Center launch

Activity 7. Support linkage between OVC activities and *Direction Interventions Spécifiques pour la Protection des Enfants*

In June, the Care and Support team joined USAID and UNICEF's project End of the Decade Review at a workshop to provide support to *Direction Interventions Spécifiques pour la Protection des Enfants* (DISPE) as it finalized the terms of reference for the National OVC Coordinator. The stated objective of this support was to enhance the efficacy and functionality of national OVC coordination and to identify ways of revitalizing it, including through the introduction of a provincial coordination structure. This workshop was funded by ProVIC. In Year 4, national coordination will be further pursued to ensure greater involvement of MINAS/DISPE in the strengthening of social protection of OVC generally, and those within this program in particular.

Activity 8. Document success stories and lessons learned

In September 2012, Melanie Coyne of IHAA documented a number of success stories from ProVIC's Care and Support work, drawing on meetings with self-help and C2C groups in Kinshasa and Bas-Congo. The meetings, which were conducted with the Home-Based and Palliative Care Specialist, were instrumental in highlighting the links between the self-help groups and the C2C groups and the role of the champion communities in supporting both. Several recommendations were made for the sustainability of the groups, including training

and mentoring of older children in the C2C groups in facilitation skills, so they will be able to take a more active role in leading groups by the time ProVIC closes out. It was observed that to increase the solidarity between groups and sustainability, representatives (president and secretary) from self-help groups would benefit from the opportunity to meet their peers within the province to share experiences and best practices, offer mutual



Documenting success stories with C2C groups in Bas-Congo

support, and identify solutions. This would also be beneficial for C2C group facilitators and animators and might offer an opportunity for peer-to-peer training on the technical inputs.

During Year 3, RNOAC, a ProVIC grantee in Kinshasa, supported 11 self-help groups to liaise with local health centers in order to hold their meetings in the facilities. These centers receive referrals from ProVIC's champion communities, so the strategy has helped to strengthen the relationship between the groups and the facilities in their health zones. Self-help group members collaborate with health facility staff, acting as a link between PLWHA and the health services. It is expected that in Year 4, other self-help groups will be able to build strong relationships with health and education facilities in a similar way.

Intermediate Result 3: Strengthening of health systems supported

Overview/Summary

During Year 3, ProVIC's capacity-building work strengthened the capacity of communities, implementing partners, and government structures to contribute to a lasting response to the AIDS epidemic. ProVIC's vision is to ensure that people infected and affected by the epidemic benefit from access to an integrated package of services. The HSS focus has been to empower different partners to work in a sustainable way by coordinating, supervising, and linking interventions. This vision is aligned with the National HIV/AIDS Strategic Plan, but is focused on the project areas of Bas-Congo, Katanga, Kinshasa, and Sud Kivu, with work starting in Kisangani in the second half of the year.

The package of services offered to communities by ProVIC included HCT, prevention through community mobilization, PMTCT, and comprehensive care and support. To ensure that these services were coordinated with government actors, the ProVIC HSS component had a two-fold approach: first, improving the reach and quality of the government's health service provision; and second, strengthening the capacity of NGOs in the community to deliver effective services.

Work with the government was designed to build a sustainable system that supports service delivery at the community, provincial, and national levels. At the community level, improved quality was achieved in the third year by running in-service training of service providers and improving the working environment, and through small investments in infrastructure. At the provincial level, ProVIC has continued to support the coordinating mechanisms and

initiatives to strengthen the collaboration between stakeholders. Previously this approach was limited to government-to-government bodies, but ProVIC ensured that it included involvement of the community as well. Finally, at the national level, ProVIC supported the establishment and dissemination of national-level policies/guidelines and training.

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

In Year 1, ProVIC conducted an analysis that identified the main gaps in service delivery by the provincial Ministries of Health, Social Affairs, and Gender and Family in four of the five ProVIC intervention provinces—Bas-Congo, Katanga, Kinshasa, and Sud Kivu. In collaboration with the PNLs and PNMLS, a plan was developed to address the gaps, including weak coordination, poor planning, weak M&E systems, and insufficient human resources and financial management. Subsequently, in Years 2 and 3, ProVIC supported each of the ProVIC provinces and government stakeholders in following this capacity-building plan.

ProVIC's work, which is detailed below, included the successful production of four comprehensive HIV service directories validated and owned by provincial stakeholders and four health-seeking behavior assessments that draw attention to the plight of MARPs. A TOT was used to cascade MINAS OVC guidelines throughout the provinces to ensure beneficiaries are linked to quality services. ProVIC organized an integrated training of 150 health service providers within the provinces to improve the quality of rapid finger-prick HIV testing, GBV programs, and PMTCT. Lastly, ProVIC's financial support led to essential government stakeholder involvement and quality development through provincial-level supervision, coordination meetings, and analysis of health zone data.

Activities and achievements

Activity 1. Set up referral and counter-referral network for all services in the champion communities and ProVIC intervention sites

In Year 2, the provincial capacity-building plans that are regularly reviewed at provincial-level coordination meetings identified the need for up-to-date referral and counter-referral HIV service directories in each of the provinces where ProVIC works. Thus in Year 3, ProVIC coordinated the production of four directories aimed at supporting referrals at three levels: government services (including both health and social services), NGOs, and community-based organizations.

ProVIC jointly developed the referral directories with the provincial governments in Bas-Congo, Katanga, Kinshasa, and Sud Kivu. The directories cover all HIV-related services in the champion communities. Each provides information on providers, their locations, and the services offered. These referral directories have been ratified by each of the provincial-level stakeholder committees and are being distributed to each institution and actor that participates in the network. This activity links to the planned support on referral tools, which have also been distributed in Sud Kivu and Bas-Congo.

Producing an HIV service directory is essential to ProVIC's aim of providing access to a complete package of HIV/AIDS services to project-supported clients and families. To ensure a continuum of services from prevention to care, support, and treatment, ProVIC's champion communities, self-help groups, and C2C groups are incorporated into referral and counter-referral processes. The directory documents the complete range of service providers to ensure

functional collaboration between all partners and to facilitate effective referrals and counter-referrals.

Review health-seeking behavior

In order to understand the motivations and needs of clients with regard to access and service delivery, ProVIC conducted health-seeking behavior assessments in the first four ProVIC implementation provinces (Bas-Congo, Katanga, Kinshasa, and Sud Kivu). The studies found that the main problem facing clients is finding effective and affordable solutions to health care. People tend to initially self-medicate. Depending on location, finances, severity of illness, or group, they may then seek care from traditional practitioners (herbalists), consult traditional spiritual healers, and/or visit prayer houses before turning to formal health facilities. Many variations to the health-seeking route were observed by the consultants. A common finding was that PLWHA in urban areas where health facilities are closer were less likely than PLWHA in rural areas to utilize their local health center. PLWHA in rural areas do not have that choice in the health centers they can go to as the distances are too great and therefore too costly for them to seek their preference for an anonymous service. Men were more reticent altogether about seeking health care.

Clients indicated that in addition to cost, health centers were regarded as formal, distant, and insensitive to their problems. Barriers include waiting time, lack of confidentiality, and issues related to the quality of services. Recommendations from the assessments included not only strengthening the quality of care at health centers, but also raising awareness of the dangers of self-medication and working with traditional healers.

The key illnesses faced by MARPs are STIs, including HIV/AIDS, gonorrhea, and syphilis, and TB. The lack of care for these groups in particular was significant. CSWs and MSM often avoid going to local health centers because of stigma, have a tendency to self-treat, and prefer private care facilities. They will travel long distances to find services offered by NGOs such as Médecins Sans Frontières. Common recommendations for these groups were to increase assistance for the formation of MARP support groups, offer STI care, and increase the availability of condoms. One consultant recommended supporting lesbian, gay, bisexual, transgender, and intersex (LGBTI) rights and tackling gender-based violence against LGBTI.

The surveys also revealed the importance of religion, as patients go to prayer houses and *marabouts*. This led to the recommendation to involve religious and community leaders to create a non-stigmatizing environment for PLWHA and their families. The studies acknowledged that while referral and counter-referral systems were weak, champion communities and volunteers play an important role in mobilizing and informing communities (through door-to-door sensitization, mass community meetings, and plays), promoting voluntary testing, distributing condoms, and referring and even taking clients to health facilities.

The surveys were shared in Bas-Congo and Sud Kivu in the last quarter of Year 3. Service providers recognized the weaknesses in the referral system and the need to develop a stronger follow-up mechanism in Year 4. The other two studies will be disbursed and discussed in Katanga and Kinshasa Provinces in the first months of Year 4.

Briefing sessions were organized with service providers in Bas-Congo and Sud Kivu to provide a common understanding of the referral network and the follow-up mechanism.

Referral and counter-referral tools (e.g., referral forms, registries) were distributed in all facilities. The follow-up and coordinating mechanism will be organized through the health zones. ProVIC has supported 27 health zones to organize these briefings. The system was effectively functional in Bas-Congo and Sud Kivu in late September 2012. Sensitization of the community with key messages will ensure community involvement in the referral network.

Horizontal learning on coordination of provincial HIV services

In the third quarter of Year 3, ProVIC organized a learning exchange visit to IHAA partner *Initiative Privée Communautaire de lutte contre le VIH* (IPC), which is based in Burkina Faso. IPC exemplifies best practices on working with governments to improve community and health structures' referral and counter-referral systems. The multidisciplinary team consisted of a representative from the national PNMLS office, one from PSSP, a grantee, and ProVIC's Health Systems Specialist.

Lessons learned from this visit contributed to the establishment of a referral and counter-referral network for HIV services in ProVIC sites to respond to the lack of referral systems and procedures found in most DRC facilities. The focus is on introducing referral tools that are adapted to facilitate the follow-up and to ensure an effective link between the community-based services and the health facilities.

The national coordinator from the PNMLS requested ProVIC's assistance with a process to develop national guidelines and directives on the community-based approach to HIV interventions. One of the areas of focus in which ProVIC will engage the government is systems to strengthen community-based referrals and counter-referrals.

Activity 2. Support MINAS to disseminate training materials in the provinces

In Year 2, ProVIC supported MINAS with the development of a training module for social workers on the care and support of OVC. In Year 3, ProVIC supported a local consultant to conduct TOT sessions for government social workers on behalf of MINAS using this module. TOTs were organized in Bas-Congo, Katanga, Kinshasa, and Sud Kivu to cascade best practices from the national level to the provincial level. A total of 67 people were trained, who were then able to train the social workers in their province. Training provincial MINAS staff enabled them to work closely with champion communities and ProVIC grantees.

Activity 3. Conduct an integrated training for service providers in champion communities

As a result of extending the reach of the champion communities to new service areas in Bas-Congo in Year 3 (Lukula, Moanda, and Patu), ProVIC was asked to extend its training in integrated HIV programming. In February and March 2012, 150 service providers, out of a target of 200, benefited from integrated trainings in Bas-Congo, Katanga, Kinshasa, and Sud Kivu. These trainings focused on concepts such as rapid finger-prick HIV testing, GBV, and PMTCT. The latter was particularly important, as it prepared service providers for the anticipated PMTCT Acceleration efforts later in the year.

Activity 4. Support joint supervision

ProVIC supported joint supervision by provincial-level government agencies, including the PNMLS, PNLS, and MINAS, in Bukavu, Kinshasa, Lubumbashi, and Matadi. Thirteen joint supervisions were conducted in Year 3 (four in Bas-Congo, four in Katanga, one in Kinshasa, and four in Sud Kivu, largely in the champion communities) to support trained service

providers in their daily work. In each province, the ProVIC Regional Coordinator and members of ProVIC's M&E team joined a team of provincial-level government supervisors to review the work of health facilities in the province, including ProVIC sites. This activity is important because it ensures two-way learning and sharing between ProVIC and the government on current contextual constraints faced by health facilities and how ProVIC's program is working. It also creates better links to health facilities and provides an opportunity to improve the quality of health facility services through mentoring of service providers. The organization of this activity with ProVIC resources ensures that this work gets done in provincial offices that frequently face a lack of resources.

Activity 5. Support health zone data review meetings

A cornerstone of ProVIC's HSS strategy is supporting health zones in monitoring their performance. To that end, ProVIC provides financial support for health zone monitoring meetings. Since health planning and decision-making is based on the quality of available data, ProVIC has encouraged grantees to participate in these health zone monitoring review meetings as a means to ensure greater harmonization of data at all levels. Previously, most community-based interventions managed by NGOs were not reported through the government's formal reporting channel—the health zone forum—which led to a fragmented system fraught with reporting discrepancies.

Since January 2012, ProVIC staff have also begun attending grantee meetings and sharing progress on community-based activities from the champion communities with health zone teams. Due to challenges around increasing PMTCT coverage in Kinshasa, ProVIC has also facilitated meetings between the provincial PNLS and health zone service providers and teams and used these meetings to share updates on PMTCT Acceleration strategies.

Activity 6. Support coordination meetings with government partners

Coordination remains the key gap identified in the provincial capacity-building plan. To ensure follow-through of the capacity plan, ProVIC has provided financial support to quarterly coordination meetings with the PNMLS. During Year 3, each provincial PNMLS office organized at least four coordinating meetings with partners involved in HIV, gender, and OVC issues. The purpose of these meetings was to share plans, targets, and monitoring data on service delivery and design strategies to improve the quality of services. These meetings have served to promote three of the four “knows”—know your epidemic, know your context, know your response—and subsequently, the focus on this analysis has helped to address bottlenecks in service provision.

Sub-IR 3.2: Capacity of NGO providers improved

ProVIC's strategy to strengthen the community response to HIV is achieved through working with 14 Congolese NGO implementing partners who have set up the champion communities, self-help groups, and C2C groups, as well as a network of volunteers. ProVIC works with these NGOs to develop their capacity in line with the “USAID Forward” strategy, that is, to ensure that they run programs effectively, efficiently, and at a high quality.

Activities and achievements

Activity 1. Build the organizational and technical capacity of NGO partners

In October 2011, an international consultant conducted two financial training sessions for all 14 NGO finance officers and directors on USAID rules and regulations to ensure their compliance. Grants Managers have since observed a positive change in financial management

systems among grantees, especially among the smaller organizations, which have made the most changes in terms of organizational structure. The project has noted an improvement in the quality of financial documentation and timeliness of financial reporting from grantees.

A second international consultant also visited ProVIC and grantees in Kinshasa and Lubumbashi to understand their organizational systems and needs, which led to the production of an integrated capacity-building strategy and work plan.

In the second quarter of FY12, ProVIC adapted the organizational capacity assessment (OCA) from USAID's flagship New Partner Initiative and piloted the OCA with Kinshasa partners. The OCA was subsequently used by the ProVIC team to assess all the remaining grantees. The results formed a baseline for each grantee. A Technical Assistance Priority Plan (TAPAP) was created to be the roadmap for ProVIC's capacity-building of the implementing partners.

A key gap identified in the TAPAP was the lack of an electronic accounting system among the grantees. In the third quarter, a training was conducted for financial staff from the 14 NGOs to learn how to use the accounting software QuickBooks and produce financial reports for ProVIC and grantee management. ProVIC purchased 17 desktops and QuickBooks software packages for all grantees prior to the training so that all partners were immediately able to apply the software in their daily financial management. A second session trained a small ProVIC core team to serve as a technical support team for ongoing assistance to grantees. This group learned the skills to set up, install, and provide backup support on the use of QuickBooks.

Technical capacity-building of the grantees has been coordinated through the respective ProVIC technical teams: Community Mobilization, HCT, and Care and Support. Examples of the technical areas that teams have introduced to grantees are the Champion Community approach and GBV. Under HCT, ProVIC has worked with the grantees to adjust the program to meet the needs of MARPs. Under Care and Support, ProVIC has bolstered the capacity of grantees to supervise and manage palliative care and C2C groups.

The teams have focused on training grantee program managers, who in turn will be supported to cascade the training to 40 technical assistants, each of whom are responsible for a Champion Community and their teams of volunteers. Details are reported under the respective components.

Activity 2. Support quarterly grantee review meetings

In order to ensure that lessons learned and best practices are shared among grantees, ProVIC has supported quarterly grantee review meetings. At each meeting, grantees discuss their performance and their planned activities for the following quarter. This exchange of information allows for the continual improvement of services delivered. Details are reported under the community mobilization component.

Activity 3. Support communities to design sustainability plans

In Year 3, prevention, care, and support activities were organized at the community level, with ProVIC partners playing a facilitation role. ProVIC assisted communities in developing sustainability plans that clarify current roles and responsibilities as well as the long-term linkages that need to be built between internal and external stakeholders to ensure continuity of the community-based work.

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

Despite the fact that project operations were interrupted during the election period early in Year 3, ProVIC rebounded and continues to make progress toward achieving its Year 3 targets. This section reviews major M&E activities and shares some lessons learned in the course of Year 3 implementation.

Activities and achievements

Activity 1. Support the ProVIC M&E system

There were three main M&E activities that can be said to have supported and strengthened ProVIC's M&E system: the database, new M&E recruits, and Regional M&E Specialists' participation in M&E training. The development of a 'cloud-based' database is one of several innovations ProVIC is employing in an effort to improve data quality/reporting, reduce the risk of double-counting, and increase project capacity to conduct rapid analyses around strengths and gaps (the results of which are to be incorporated into project activities). Throughout Year 3, the National M&E Specialist continued to work closely with the PATH/Washington, DC-based M&E advisor (and partner Vera Solutions) to refine the architecture of the database, ensuring that it will have the capacity to collect relevant data to produce strategic information for decision-making and project planning. It is expected that efforts to render the database optimally operational will be an iterative process, taking into account new developments, and thus will continue in Year 4. Current revisions include configuring the architecture so that GBV and commodities-related data will be collected.

Two additional staff were added to the M&E unit in Year 3. The M&E assistant, recruited in May 2012, manages the database and supports the National M&E Specialist in monitoring implementing partners in Kinshasa. The Kisangani M&E Specialist, who came onboard in July 2012, is responsible for all M&E-related activities in the province. With the Kisangani expansion, the project currently has six M&E staff.

Finally, two Regional M&E Specialists had the opportunity to strengthen their skills by participating in a MEASURE Evaluation HIV/AIDS workshop in Dakar, Senegal, in the third quarter. PATH non-ProVIC institutional funds were used for the training, since we felt they were important for the professional development of the involved staff. The Sud Kivu and Bas-Congo specialists learned about important M&E concepts and tools, including the role of strategic information in decision-making, evaluation designs, development of M&E plans, and development and interpretation of indicators. The new M&E knowledge reinvigorated their commitment to producing high-quality reports and providing high-quality technical support.

Activity 2. Strengthen implementing partners' M&E systems

While the advantages of having a database are undeniably significant, the extra efforts required to learn and apply the new system (for storing, analysis, and reporting data) are also equally significant. This has certainly been the case for ProVIC since the launch of the database. ProVIC's implementing partners from Bas-Congo, Katanga, Kinshasa, and Sud Kivu received an intensive four-day data entry workshop in the second quarter of Year 3. The hands-on workshop allowed participants to practice inputting data into the Excel-based data card templates and provide feedback that was then used to refine the data cards. During the transition period (April–September 2012), where implementing partners are submitting monthly reports via the data cards, the M&E Specialists and assistant spent considerable time

coaching some partners on the monthly data entry work. Applying these new skills has required more time than anticipated to complete monthly reporting by both implementing partners and ProVIC, especially among partners with limited or no Excel experience. Although there have been vast improvements in partner capacity levels, a few still require regular follow-up to submit the monthly data cards.

Activity 3. Strengthen the data quality assurance system

ProVIC provides technical support and guidance to implementing partners through regular supportive monitoring visits and routine data quality assessments (RDQA). One strategic information enhancement has been for ProVIC M&E staff to regularly conduct joint site visits with other ProVIC technical managers. The joint monitoring site visits encourage greater interdepartmental collaboration and dialogue on both M&E and technical issues; implementing partners also receive ProVIC inputs on both programmatic and M&E issues in one visit. Each M&E Specialist also conducts DQAs to examine in-depth data collection and reporting issues. With the departure of the Katanga M&E Specialist/DQA lead at the beginning of Year 3, the Sud Kivu M&E Specialist assumed the lead role in ProVIC's DQA activities. In the second quarter, with the M&E team working in pairs, routine DQA exercises were conducted with one NGO grantee in Bas-Congo, two grantees in Katanga, and three in Sud Kivu. Overall in Year 3, M&E Specialists were able to conduct three DQAs with different implementing partners. In the last quarter of Year 3, the lead DQA staff member worked with the Washington, DC-based M&E advisor to review ProVIC's DQA efforts from June 2011 to July 2012 and strategize for Year 4's efforts. Going forward, M&E Specialists will conduct RDQA of at least four different implementing partners each quarter, starting with those that have been struggling the most.

Another innovative strategy ProVIC used to improve data quality and at the same time strengthen implementing partner M&E capacity is the Peer-to-Peer LCD model. In the third quarter, ProVIC began piloting this model strategy to Kinshasa, coordinating monitoring activities with one "lead grantee." In Kinshasa, PSSP has taken the lead in providing technical M&E advice to two other grantees which were deemed "learning grantees." The pilot was anticipated to last about two months; however, since the learning activities are coordinated based on each organization's



schedules, the total length of time will more likely be around six months. PATH/Washington, DC, presented the preliminary results of the pilot model at a USAID-sponsored summit on local capacity development in Washington, DC, in June 2012. One result of the peer M&E capacity development approach was an immediate adoption of a desired M&E practice; based on the lead grantee's showcase of their M&E filing system—a basic but chronologically organized and labeled set of folders and binders—the two learning grantees were quickly able to make this basic change to their filing system. Although this may seem rudimentary as an

M&E best practice, a functional filing/organization system is more likely to yield better reporting. The peer approach resulted in rapid positive change in this organizational M&E system, whereas encouragement of these types of changes over two years by the project's National M&E Specialist had been fruitless. Based on this and other positive outcomes, all grantees were inspired to learn M&E from their peers, and this peer model approach will be expanded in Kinshasa and scaled up to other provinces.

Activity 4. Support national and regional M&E systems

At the national level, ProVIC participated in a week-long PNLs-hosted workshop to incorporate new PMTCT protocols and guidelines into the National Health Development Plan 2012-2016. ProVIC participated as experts in PMTCT M&E to work on, among other contributions, standardized national PMTCT data collection tools. The workshop resulted in a draft strategic Health Sector Plan as well as harmonized assessment tools for monitoring national-level health indicators.

In Bas-Congo, ProVIC conducted a joint monitoring visit with governmental partners—the PNLs, the PMNLS, and the *Division des Affaires Sociales*—to ensure that facilities were following national clinical norms. Several challenges were found, including misinterpretation of the food support indicator and poor supervision of the health facilities by central offices. In follow-up, the trip report and recommendations were shared with all concerned parties and the joint team will visit quarterly to ensure and support implementation of the recommendations. In Katanga, the M&E Specialist organized a workshop with the PNLs to provide a refresher training to ensure partners are using the tools correctly as well as following national norms.

SECTION 2: PROGRAM MANAGEMENT

Administration and finance

Administration

Administration/Operations activities and issues for Year 3 included:

- Acquisition of Kinshasa regional office space in the PNMLS building.
- Start-up of the Kisangani office, which opened in June 2012. Office space was secured and the full complement of office staff was recruited and hired, including technical and operations personnel.

Finance

Financial activities/issues during this past year included:

- Financial review by USAID: From July 2011 to September 2011, the USAID Mission in DRC conducted a financial review in ProVIC's Kinshasa office subsequent to the RIG audit conducted in January 2011.
- Bukavu fraud case: The Bukavu office experienced a fraud perpetrated by the Bukavu Regional Grants Manager in January 2011 which was discovered quickly due to ProVIC's established accounting and compliance oversight practices, and which resulted in termination of the grant manager's employment. ProVIC also requested and received reimbursement of the stolen funds from the Bukavu bank involved, as the bank had not followed the check-signing practices/protocol instituted with it by ProVIC to ensure proper financial controls. The bank recognized that this lapse on its part in following the proper procedures had facilitated the fraud.
- External audit of Bukavu office: Following up the fraud carried out by the Bukavu grants manager, the project sent an external auditor to the Bukavu ProVIC office to examine the office's overall financial operations. Coming out of the audit, the office's practices and financial oversight were both strengthened and the office's new operations personnel were trained in proper financial procedures.
- Internal audit for PATH: A routine internal annual audit was conducted by PATH/Nairobi in July 2012.
- The Field Accounting and Compliance team from Chemonics headquarters in Washington, DC, conducted a project financial review in the Bukavu, Kinshasa, and Matadi offices in June 2012.

Recruitment

The project added some new positions (as included in ProVIC contract modification #7) and replaced departed staff.

New positions added and filled after successful recruitment:

- Bukavu: Office Manager.
- Katanga: OVC Specialist, PMTCT Specialist.

- Kinshasa: Finance Assistant, Administrative Assistant, Grants Manager, Accountant Assistant, Community Mobilization Assistant, M&E Assistant, Provincial Pediatric Specialist, OVC Specialist.

The project experienced the departure of the following staff, all of whom have been replaced, except for the Kinshasa Prevention Specialist and Bukavu Prevention Specialist.

- Bukavu: Grants Manager, Accountant, Office Manager, Prevention Specialist.
- Katanga: Office Manager, Accountant, M&E Specialist.
- Kinshasa: Prevention Specialist, PMTCT Specialist.

Procurement

Equipment purchases made by the ProVIC program in 2012 were conducted according to ProVIC procurement procedures and USAID guidelines and included PIMA™ CD4 analyzers, as well as computers with accounting software for the 14 ProVIC standard grant recipients.

Several purchases of pharmaceuticals and commodities by PATH occurred in 2012, as ProVIC transitioned from procuring its own pharmaceuticals to receiving such support via the USAID-funded SCMS project. PATH procured two orders of pharmaceuticals in Year 3 before the involvement of SCMS. These orders were procured through coordinated efforts of the ProVIC Kinshasa Logistics team and the PATH Headquarters Procurement division:

- In DRC, the logistics department supported the selection of items, the quantification of items based on forecasts and annual targets for each component, vendor selection, and obtaining exemption for international market procurements.
- At PATH Headquarters, the Procurement division established the purchase orders, tenders introduction, suppliers selection, and market confirmations for international purchasing.

ProVIC has used two types of vendors:

- Local suppliers, including Arauphar SPRL, Wagenia SARL, Mlabotype, Essor Equipment, Infortel, and Computech.
- International suppliers, including TRIMED and Wagenia SARL Brazzaville.

Table 5 below provides a summary of pharmaceutical and commodities purchases made by PATH/ProVIC in Year 3 before the involvement of SCMS.

When ProVIC joined the SCMS procurement system, SCMS took over procurement of pharmaceuticals and laboratory inputs through its procurement and supply system. Through SCMS, ProVIC submitted three orders in 2012, two “PMTCT orders” and one global order of supplies/commodities for activities outside of PMTCT, such as the HCT work (for community-based and mobile counseling and testing).

Table 5. Summary of purchases made by PATH/ProVIC in Year 3.

Description	Component	Supplier	Value	Purchase order		Notes
				Number	Date issued	
Laboratory equipment	HCT, PMTCT	Essor	\$67,093.00	110822	27-Jul-11	Received: two items completed
HIV test kits	HCT, PMTCT	Wagenia SARL BZ	\$120,761.40	110897		Received
Cotrimoxazole suspension	PMTCT	Wagenia SARL	\$276.00	061	18-Jan-12	Received
Laboratory equipment	HCT, PMTCT	Mlabotype	\$53,450.00	120106	31-Jan-12	Received
HIV test kits	HCT, PMTCT	Wagenia SARL BZ	\$90,927.89	120132	03-Feb-12	526 Determine™ test kits stolen
Home care items	Care and support	Arauphar	\$42,478.80	120658	16-May-12	Received
PIMA™ CD4 analyzers (five kits)	HCT, care and support	Wagenia SARL	\$44,305.00	106	08-Jun-12	Received
Malnutrition items	Care and support	Mtlabotype	\$10,252.00	120825	12-Jun-12	Received
QuickBooks computer kits	HSS	Computech	\$25,500.00	120829	14-Jun-12	Received
TOTAL						\$414,911.79

BZ: Brazzaville.

ProVIC experienced some procurement-related challenges during this year. In June 2012, the theft of 526 Determine™ HIV tests kits (52,600 tests) was a terrible blow to ProVIC's activities and created stockouts for community and mobile HCT activities, although support to PMTCT sites was sustained. An emergency order was placed through SCMS, which arrived approximately three months later and mitigated the impact of the theft. Another significant difficulty was the delay associated with customs clearance, which has become an increasingly cumbersome process, with increased numbers of certifications and signatures required.

Grants management

ProVIC's grants management system supported a large, geographically diverse, and complex set of 35 local partners in FY12. This systems is central to the project's success. These 35 partnerships included 14 local NGOs, eight private or Catholic church-affiliated health facilities, and 13 public health facilities across 27 health zones and five provinces. ProVIC supported these local partners through nearly \$2.7 million in financing, as follows:

- 14 standard grants issued to local NGOs \$2,161,119
- 8 fixed-obligation grants issued to private/church-affiliated health facilities \$190,251
- 13 collaborative agreements issued to public health facilities \$327,516

Election-related unrest in December 2011 throughout the country and USAID approval delays yielded first-quarter implementation delays, but ProVIC responded quickly by promptly disbursing funds and supporting NGOs in developing "catch-up plans," among other strategies. The reactivity of ProVIC's granting system to these challenges enabled the vast majority of partners to rebound and meet their annual targets as planned—with activities ranging from HCT, PMTCT, and community mobilization to in-service health provider trainings and care and support for PLWHA and OVC.

ProVIC continues to sprint to keep pace with the increasing volume and types of local financing mechanisms, which is expected to nearly triple from Year 3 to Year 4. Four grants managers were hired in Year 3 to support these expansions—in Bukavu, Kinshasa, Kisangani, and Matadi—for a total of six grants managers across five provinces, a complete complement.

Strengthening local capacity is among ProVIC's ongoing commitments and priorities—which, in Year 3 for the project's granting system, has included continued capacity-building for our Grants Management team and local partners alike. First, recognizing that our Grants Management team brings varying degrees of ProVIC and USAID experience, PATH's Washington, DC- and Seattle-based project and contracts teams provide mentorship and management support while exploring minimal-risk ways to progressively transition selected grants-related processes from Washington, DC, to Kinshasa as appropriate. Such ongoing transitions recognize that promoting country ownership and accountability importantly includes fostering this ownership internally within ProVIC, and not just external to ProVIC.

The team has also championed the development and use of internal grantee monitoring tools to ensure effective, routine partner oversight and improve system efficiencies. Finally, a one-week, national Annual Grants Workshop in July 2012, which included grants managers and regional coordinators from all five operating provinces, served to elevate the role of regional coordinators as day-to-day mentors to regional grants managers and reinforce the importance of strong coordination across the M&E, Grants Management, and technical teams.

It cannot be understated that these public and private partners continue to bring myriad capacity strengths and weaknesses to ProVIC in the face of their unique, localized challenges. These include NGO partners like AMO-Congo and Femme Plus, which persevere amidst ongoing management and administrative challenges in part due to the sheer scope of working across multiple provinces; health providers in Bas-Congo PMTCT facilities who have never used Excel, let alone a computer, for data entry; finance officers in Kinshasa using QuickBooks for the first time to track their organizations' finances; and sites in Sud Kivu whose staff are expected to consistently produce results despite un-navigable terrain and sometimes serious security risks.

ProVIC's Grants Management team works closely with its Regional Coordinators, M&E Officers, and Technical Specialists to creatively address these diverse needs and challenges, and continued capacity-building efforts among our local partners are reaping visible, sustained results. The majority of the project's 14 NGO grantees now submit timely technical and financial quarterly reports, for example, and increased engagement of ProVIC's Regional Technical Specialists and a web-based document review system have accelerated approval and payment processing timelines. Strategies have included supporting peer-to-peer capacity-building activities; using organizational capacity assessments to inform decision-making; convening quarterly grantee review meetings; using routine M&E database reports from the M&E team to inform supportive supervision; and conducting routine site visits.

As ProVIC looks ahead to Year 4, the complex machinery of its grants management system continues to adapt to the expanding partnerships, evolving programming trends, and complex, emerging needs on the ground. In addition to continued engagement with all existing local ProVIC partners—a testament to the strong relationships cultivated between ProVIC, its local partners, and national and provincial government—the project will also forge agreements

with more than 20 new health facilities and 34 health zones in Year 4. These plans include a performance-based financing pilot in Kinshasa, PMTCT Acceleration, the project's recent expansion into Province Orientale, and the addition of GBV prevention and response services.

SECTION 3: ENVIRONMENTAL MONITORING AND MITIGATION ACTIVITIES

Work plan activity	Potential negative environmental consequences	Status report
HIV/AIDS counseling and testing	HCT generates biohazardous health care waste such as syringes and other hazardous sharps, which if not disposed of properly are a health risk for those who come in contact with them. It also requires drawing blood, which then must be properly stored and disposed of.	<ul style="list-style-type: none"> • HCT partners have waste management plans in place as part of the grant award. • Orientation includes provision of national norms in waste management to all 30 sites and 14 grantees. • Trained 150 HCT, PMTCT, and palliative care providers in effective and proper management of biomedical waste. • Trained 36 HCT service providers in Kinshasa in HCT waste management. • Distributed Environmental Monitoring and Mitigation Activity kits to 14 grantees and participating health facilities (30 HCT, 42 PMTCT) to adequately and safely dispose of HCT biomedical waste (plastic containers, cleaning materials, sharps boxes, gloves, boots, safe pits or burial sites, or facilities for incineration or other safe disposal).
Prevention of mother-to-child transmission of HIV	PMTCT includes HCT and the risks mentioned above. In addition, the labor and delivery process includes the use of syringes, needles, and other sharps; and also necessitates a way to remove the blood and other bodily fluids and clean and disinfect the delivery area to prevent contact with potentially hazardous fluids.	<ul style="list-style-type: none"> • Maternities and hospitals delivering PMTCT services have waste management plans in place, including how to maintain a sterile environment, as part of the grant award. • Orientation includes provision of national norms in waste management to all sites. • Provided refresher training for providers in 16 existing PMTCT sites and identified training needs in 25 new sites. • Upgraded incinerators in 16 existing PMTCT sites and identified needs in 26 new PMTCT sites. • All PMTCT sites have adequate equipment to dispose of waste safely (sharps boxes, safe pits or burial sites, or facilities for incineration or other safe disposal).
Palliative care (medical services such as treatment of opportunistic infections and STIs, provision of prophylaxis)	Palliative care for PLWHA includes, as discussed above, both use of hazardous sharps and exposure to bodily fluids, which may be infectious.	<ul style="list-style-type: none"> • All ProVIC palliative care and caregiver partners have waste management plans in place. • Orientation includes provision of national norms in waste management to all grantees. • Grantees have received palliative care kits that include, among other items, adequate equipment to dispose of waste safely (sharps boxes, safe pits or burial sites, or other safe disposal).

SECTION 4: CHALLENGES AND PROPOSED SOLUTIONS

Challenge	Proposed solution
Intermediate Result 1: HIV counseling and testing and prevention services improved in target areas	
Sub-IR 1.1: Communities' ability to develop and implement prevention strategies strengthened	
Delays in the grants approval process amidst additional uncertainties during the DRC election period.	<ul style="list-style-type: none"> • Adapt the grants application cycle to meet project needs at each step of the process, ensuring financial resources are available in time to achieve project results. • Put in place a catch-up plan with concrete steps to ensure we meet our results. • Communicate closely with USAID during the approval process.
Keeping community workers engaged and participating in activities within the DRC context.	Work with communities to identify alternative (non-financial) motivation/incentives based on locally available resources.
Delays in procuring and clearing Champion Community kits through customs delayed implementation of community mobilization and education activities.	ProVIC should immediately procure materials at the beginning of each project year once USAID approves the work plan. ProVIC will continue to work with the USAID Mission and US embassy to accelerate work plan approval and customs clearance processes.
Weak referral and counter-referral systems.	ProVIC is working in close collaboration with the PNLS and PNMLS to adapt/establish functional referral and counter-referral systems. These enhanced referral systems will be rolled out at the provincial and health zone levels to ensure maximum coordination and understanding of the actors, tools, and system.
Limited access to prevention services, even with mobile HCT. ProVIC is unable to meet the growing demand for HIV services, particularly in sites where previous services supported by other donors have ceased.	ProVIC cannot alone meet the demand of HCT in DRC. Only when the DRC government and/or donors decide to increase the resources for HCT will the demand be met. ProVIC can work to ensure that its limited resources are used in the most targeted manner by identifying high-risk populations for the majority of the services.
Sub-IR 1.2: Community- and facility-based HCT services enhanced	
Lack of motivation and/or interest among certain ECZS to monitor service providers—particularly community and mobile HCT activities—in their health zones.	ProVIC staff will identify opportunities to motivate ECZS through <i>Accords de Collaboration</i> with the health zones—identified during the Year 4 planning process as a key new intervention. Further, ProVIC will work within the Champion Community structure, emphasizing the importance of teamwork and civil society collaboration/participation with ECZS, including during Champion Community Steering Committee meetings.
Weak integration of family planning in HCT facilities and other sites.	Now that all sites have been trained in family planning, ProVIC staff will coordinate with the PNMLS, USAID, and other HIV implementing partners to identify ways to supply HCT sites and maternity wards equipped with family planning commodities and supplies.
The volatile DRC presidential election period disrupted HCT site activities, communities, and project staff and further fueled implementation delays.	The political system seems to have stabilized in DRC, which improves our operating environment.

Challenge	Proposed solution
Sub-IR 1.3: PMTCT services improved	
Delay in start-up of PMTCT Acceleration and training delays (training provided by FHI 360/CDC). This situation affected all partners and had an impact on programmatic activities, leading to the delay of clinical services and attainment of targets. PMTCT Acceleration sites did not begin implementation as originally planned.	While ProVIC cannot control the PEPFAR funding cycle or the decision-making processes within USAID or the CDC, the project can react quickly when PEPFAR does coordinate its activities well. In addition, ProVIC will actively participate during PMTCT TOPs and work directly with new providers at PMTCT Acceleration sites to ensure their knowledge of new processes.
Weak rates of women returning to deliver at the PMTCT site where they were tested or had received PMTCT services.	To address this challenge, ProVIC will pilot the Mentor Mother approach to improve the retention and adherence of women in PMTCT in Year 4. ProVIC will also strengthen the supervision of providers during home visits and strengthen the referral system for following women from antenatal care through labor and delivery services.
Low participation of male partners in PMTCT services.	To increase male partner participation, ProVIC will reinforce referral and counter-referral mechanisms between facilities and champion communities using support groups; offer extended hours of services such as weekend, holiday, and after-hours services for men; and improve the messaging on the invitation sent home to male partners.
Sub-IR 1.4: Community- and facility-based GBV prevention and response services strengthened	
Delay in distribution of equipment and supplies, including sexual violence post-exposure prophylaxis kits, to health facilities (eight PMTCT facilities in Kinshasa and Kisangani) due to challenges in creating an appropriate funding mechanism for variable costs within a fixed-obligation grant agreement structure.	Any line items for variable costs for medical management of GBV cases have been shifted to a separate <i>Accord de Collaboration</i> for those facilities providing GBV services.
Delay in training of health care providers due to delays in validation of the MOH/PNSR training curriculum for health care providers in the provision of services for GBV survivors.	The ProVIC GBV Specialist attended a TOT and obtained approval from the PNSR to proceed with training of health care providers by PNSR-trained facilitators. As soon as possible after the TOT, ProVIC held the training for health care providers in Kinshasa.

Challenge	Proposed solution
Intermediate Result 2: Care, support, and treatment for people living with HIV/AIDS and orphans and vulnerable children improved in target areas	
Sub-IR 2.1: Care and support for PLWHA strengthened	
Underperformance on TB-related targets due to a misunderstanding of the TB screening indicator as a treatment indicator and due to long stockouts of TB diagnostic tools and medications.	ProVIC proposes to engage a TB officer in Year 4 who will be responsible for scaling up TB activities within the program and ensuring we reach our targets. The officer will strengthen TB screening based on the WHO algorithm, early detection of TB cases, and linkage to TB treatment and adherence support. ProVIC will intensify its screening of TB in self-help groups and health facilities and improve referrals by working with volunteers from CAD (former TB patients). ProVIC will share information with national TB actors when stockouts of TB supplies, diagnostics, and treatment occurs. Under Care and Support, the palliative care and PHDP key messages will be fully cascaded to the self-help groups. In addition, ProVIC will work increasingly closely with the TO2015 project to improve results and the tools to report results.

Challenge	Proposed solution
Malnutrition and food scarcity among PLWHA.	The recent withdrawal of funding for food from the ProVIC budget (with PRONANUT taking over responsibility for this) has created challenges for our partners, since malnutrition is one of the most pressing problems for PLWHA. However, there is a possibility of working with FAO to provide agro-pastoral support to ProVIC beneficiaries. ProVIC intends to submit a proposal to FAO for a collaborative project.
Throughout the country, PLWHA have difficulty obtaining CD4 tests because of the lack of testing facilities.	WHO recommends that PLWHA be put on ARVs when their CD4 count drops below 350/mm3. Due to the lack of CD4 testing facilities in all provinces, ProVIC has decided to incorporate mobile point-of-care PIMA™ CD4 testing within its range of services. These PIMA™ tests can be used to check the CD4 count of PLWHA in the self-help groups.
Lack of access to ARVs in the country. Only 12 percent of the 436,000 people who are eligible ³ are on ARVs. This figure is countrywide and not what has been achieved by the program.	ProVIC's efforts to provide ART are hampered by the shortage of ARVs and the uncertainty of supplies across the country. Even before the Global Fund froze its program in May 2011, DRC had stockouts of first-line ARVs, no availability of second line treatments, and insufficient capacity to provide government services to administer complex medical treatment. This seriously affects the number of people who manage to obtain ARVs despite being eligible. At the national level, the ProVIC Director continues to advocate for USAID support to increase the supply of ARVs in DRC. At the project level, it is recognized that the prevention of opportunistic infections and the promotion of general health of PLWHA is key to delaying the need for ARVs PLWHA. However, the future of PLWHA in DRC cannot be assured if there is not guaranteed access to ARVs.
Morbidity and mortality linked to malaria, especially in endemic areas.	The linkage to malaria will be addressed in Year 4 through increased emphasis on referrals through the self-help groups.
Sub-IR 2.2: Care and support for OVC strengthened	
A continuing challenge is weak linkages to health facilities, as evidenced by only 54 percent of the health referral target being achieved. However, low referral levels also reflect barriers to health care (including the cost of health care, distance, and lack of supplies).	In order to address one of the barriers to health care, ProVIC will introduce <i>mutuelles de santé</i> for OVC, whereby the grantee supports the cost of health care of those most in need to ensure successful referrals. ProVIC will also recruit three Regional Health Systems Specialists who will focus on strengthening community and health facility referrals.
A challenge for families and guardians is the ability to afford care for OVC.	Although IGAs were not a ProVIC focus, the project has been successful in promoting income generation. In Year 4, ProVIC will strengthen IGAs for families of OVC in collaboration with LIFT, using a VSLA approach to contribute to increased economic support from families to OVC care, and devise a means of selection based on economic need.

³ Republique Democratique du Congo Programme National Multisectoriel de lutte Contre le SIDA. *Rapport d'Activite sur la Riposte au VIH/SIDA en R.D.Congo*. Available at: http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2012countries/ce_CD_Narrative_Report%5B1%5D.pdf.

Challenge	Proposed solution
Protecting children from abuse and maltreatment is challenging within a context where there are low levels of understanding of what abuse involves and very few effectively functioning community or government systems to which organizations can refer children.	ProVIC will continue to work to address this challenge through C2C groups and PLWHA self-help groups through networking with stakeholders and partnerships with human rights organizations to increase the accessibility of support on rights in order to protect against abuses, violations, stigma, and discrimination.

Challenge	Proposed solution
Intermediate Result 3: Strengthening of health systems supported	
Sub-IR 3.1: Capacity of provincial government health systems supported	
Ensuring a well-functioning, systematic, and inclusive referral network and follow-up mechanism in all ProVIC sites.	ProVIC plans to appoint three regional staff members in the USAID hotspot provinces to promote effective referral and counter-referral systems, linking community structures and health facilities offering HIV services within the health zone. These Regional HSS Referral Specialists will have a dual community and HSS role which will help people access the comprehensive care and support they need from informal providers (in the community) and formal in the health facilities.
Sub-IR 3.2: Capacity of NGO providers improved	
Lack of time and personnel meant it was difficult to follow up on the technical assistance priority action plan for each grantee.	ProVIC recently hired an NGO Capacity-Building Specialist to work with each grantee and follow up on the Organizational Capacity Assessment and Technical Assistance Priority Action Plan. This will enable the National HSS Specialist time to provide guidance to the Regional HSS Specialists and continue the major focus on aligning ProVIC's work with that of the government and strengthening government health systems.
Need for stronger integration of services provided by ProVIC and other partners.	ProVIC's work in Year 4 will focus on the integration of its own components and integration into program health zones (building on past work at the provincial level). Joint regional- and community-level supervision will assist in this integration process.
Sub-IR 3.3: Strategic information systems at the community and facility levels strengthened	
Despite ProVIC's persistent follow-up and ongoing coaching, some implementing partners continue to struggle with both PEPFAR indicators and complete and timely reporting.	To address the issue of understanding and operationalizing PEPFAR indicators, ProVIC has developed a simple guide to key PEPFAR indicators. This "mini-manual" will be translated into French and be available to implementing partners and ProVIC staff in the first quarter of Year 4. Further, ProVIC will continue to provide intensive follow-up/guidance to partners to complete data entry for monthly reports. After the Year 3 reporting, ProVIC will review partner progress (in November 2012) and develop regional operations plans to provide onsite hands-on technical support as necessary.
Entering historical data into the database has proven to take much longer than anticipated.	ProVIC is monitoring the progress of the efforts in the first quarter of Year 4. The National M&E Specialist together with the Deputy Chief of Party will draft a plan with a specific time frame and resources needed to finish entering historical data for all provinces.

SECTION 5: SUCCESS STORIES

SUCCESS STORY

Combating HIV in the Luisha mining region

From the local community to multilateral donors, ProVIC leverages the strengths of stakeholders at many levels for an effective HIV/AIDS response



Above: A community health worker from local NGO partner World Production prepares rapid HIV test results in a mobile VCT tent in Luisha. Below: National and provincial teams from ProVIC, the PNLS, and the PNMLS pose during a joint supervision visit.



In 2009, farmers discovered rich copper deposits about 80 kilometers outside of the Democratic Republic of Congo's (DRC) second largest city, Lubumbashi. With the opening of the Mbola concession just south of Luisha—formerly an open pit copper and cobalt mine—came an influx of people looking to make a living, from miners and truck drivers to policemen and shopkeepers. A bustling city of about 31,000 people was born, along with high HIV-risk activities like commercial sex and alcohol and drug abuse. The need to prevent the spread of disease, especially among highly mobile populations most vulnerable to infection, also soon emerged.

Recognizing this need, the Ministry of Mines asked the National AIDS Control Programme (PNLS) in late 2010 to launch an HIV prevention campaign in Luisha. The PNLS called on the DRC Integrated HIV/AIDS Project (ProVIC), the country's largest HIV/AIDS initiative, for help. US Global AIDS Coordinator Eric Goosby also paid a visit to Luisha, joining their call for an urgent response.

ProVIC quickly mobilized this response at multiple levels. The project asked local nongovernmental organization (NGO) partner World Production to extend their HIV awareness, condom distribution, and mobile voluntary counseling and testing (VCT) clinics to Luisha. After the first mobile VCT clinic revealed a high HIV seroprevalence of 8.9 percent, World Production decided to engage the Katanga Association of Artisanal Mining Operators and the community in educational and awareness-raising sessions. ProVIC also collaborated with international NGO Population Services International to target most at-risk groups through behavior change communication campaigns. And the PNLS provided national- and provincial-level support through community health worker trainings and joint supervision visits with the National Multisectoral AIDS Control Programme (PNMLS).

Building on these successes, ProVIC is now establishing a Champion Community in Luisha, linking community-level activities to high-quality facility-level services at Luisha Health Center, and integrating services like family planning and sexually transmitted infection treatment. With antiretrovirals from the Global Fund, Luisha Health Center will also redouble efforts to prevent HIV transmission from mothers to their babies. And a collaborative agreement between ProVIC and the Kapolowe health zone will help strengthen coordination, oversight, and procurement and referral systems at the health zone level for a comprehensive, sustainable response.

Photos: Jean Claude Kiluba/ProVIC



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DEMOCRATIC REPUBLIC OF CONGO

SUCCESS STORY

Under one roof: Integrating TB and HIV services in Lubumbashi through multilateral collaboration

From diagnosing TB to preventing mother-to-child transmission of HIV, ProVIC helps mobilize partners and resources at many levels for a comprehensive HIV/AIDS response



Top: Kenya General Reference Hospital. Middle: A biomedical waste incinerator constructed through ProVIC. Bottom: US Ambassador James Entwistle with a post-test club and ProVIC's Katanga regional coordinator outside the hospital.

U.S. Agency for International Development
www.usaid.gov

In the southeastern mining hub of Lubumbashi, in the province of Katanga, the government-run Kenya General Reference Hospital is a key health care provider for an estimated 167,000 people. Over the past year, the Democratic Republic of Congo (DRC) Integrated HIV/AIDS Project (ProVIC) has worked with partners at all levels—from the surrounding community and provincial government to multilateral donors like the Global Fund—to integrate additional health services and ensure a strong continuum of care for those served. This includes pregnant women, who make up a quarter of the roughly 800 clients seen by Kenya's 112 staff each month.

Kenya General Reference Hospital is a longstanding tuberculosis (TB) screening, diagnostic, and HIV treatment site, consistently reporting much higher HIV rates than those found among Lubumbashi's general population. Of the more than 1,600 people tested for TB over the past year, a striking 28 percent also tested HIV positive. The hospital's health services are both integrated and complementary, ranging from internal medicine, surgery, and pediatrics to maternity, pharmacy, and laboratory facilities. Service expansions were facilitated by two key partners: USAID and the Global Fund, which in 2006 first supported the integration of HIV counseling and testing into Kenya's TB diagnostic and treatment center.

With funding from ProVIC, Kenya was the province's first health facility in 2011 to launch prevention-of-mother-to-child transmission of HIV (PMTCT) services in line with new World Health Organization and DRC national guidelines. The Global Fund once again joined in to help, including by providing much-needed antiretrovirals (ARVs) for HIV-positive mothers, their exposed babies, and those co-infected with HIV and TB, the leading killer of people living with HIV/AIDS (PLWHA). ProVIC, in turn, introduced CD4 testing for all HIV-positive clients, integrated family planning and PMTCT services, and built an incinerator for biomedical waste. The National Multisectoral AIDS Control Programme, working in partnership with US President's Emergency Plan for AIDS Relief implementing partners, also helped train Kenya's health providers on this integrated HIV service package. Co-locating HIV prevention and care services in this way has ensured both strong integration and a better continuum of care at the facility level—a systemic weakness across the country's health system.

Nearby, champion communities established via ProVIC extend this continuum of care for HIV-positive clients and their families to the community level: home-based care visits help recover those lost to follow-up and monitor patient adherence to ARV and TB treatment, and PLWHA self-help groups called post-test clubs hold regular meetings. For ProVIC, integrating HIV services under one roof means more than just working at the facility level: it means extending care and support services to the community for a comprehensive, sustainable HIV/AIDS response.

Photos: Teddy Kalema

October 2012



SUCCESS STORY

Positive living with dignity: Self-help groups generate sustainable income for people living with HIV/AIDS

Through income-generating activities made possible through community microcredit, people living with HIV/AIDS are becoming more economically self-sufficient



With a start-up loan from her PLWHA self-support group's solidarity fund, Mama Antho (left) has launched a small business selling pig food, which has allowed her to support herself and her family. About 560 eligible adults and children benefited from microcredit in ProVIC's third year alone—from growing vegetables and setting up cyber cafes to raising chickens and selling textiles.

With support from ProVIC's local nongovernmental organization (NGO) partners, people living with HIV/AIDS (PLWHA) become more financially independent by using start-up loans from their self-help groups to set up income-generating activities. Ntembo, a self-help group in Bas-Congo that receives seed grants through a local NGO called JADISIDA, is one of 196 such groups established by the Democratic Republic of Congo Integrated HIV/AIDS Project (ProVIC)-supported champion communities across the country. More than 4,700 PLWHA received integrated care and support during ProVIC's third year alone. This included services like self-help groups and home-based care visits.

In early 2012, members of the Ntembo PLWHA self-help group met to select a group member to benefit from the next round of earnings from their solidarity fund. They chose Mama Antho, who then received \$500 in microcredit to set up her own income-generating activity. She used these funds to buy a stock of soya beans, which she began selling as pig food from a small shop that she set up in a busy part of Bas-Congo's capital, Matadi. She also received training on how to manage her business.

"Business is good!" says Mama Antho. She buys each bag of soya beans for about four dollars and sells them at six dollars apiece for a healthy profit. The customers are steady, and many buy in bulk.

Mama Antho's new business venture has empowered her to make a better life for herself and her family. Her earnings have allowed her to send her three children to school, give them more nutritional meals, and pay for their much-needed dental care. "My children are much happier because they thought their education would have to end," she reflected. "Now they will complete their studies."

Now better equipped to take care of herself and her children, Mama Antho is treated differently by her family. Originally shunning her upon learning her HIV status, her family now sees her as a more self-sufficient, productive member of society. In her community, ProVIC-supported messaging reinforces fighting stigma against PLWHA.

Five months after receiving her start-up loan, Mama Antho is now making low-interest repayments to the solidarity fund to kick-start another loan to someone else in her group. She believes in the sustainability of this system, she says, because it is grounded in group solidarity, and she feels a strong sense of duty in repaying her loan so that someone else can benefit—just as she has.



SUCCESS STORY

Protecting legal rights for people living with HIV/AIDS

By linking ProVIC’s PLWHA self-help groups to local resources and expertise, both adults and children in Kinshasa receive the legal protection and advice they



Lawyers from Centre de Solidarite Nationale (CSN) in Kinshasa, the oldest legal aid service in the country with nine full-time lawyers. CSN is a member of the Menelik Partnership and Lawyers Without Borders.

Stigma and discrimination are daily realities for many people living with HIV/AIDS (PLWHA), including in the Democratic Republic of Congo (DRC). They prevent PLWHA from disclosing their status, seeking and accessing the care they need, and actively participating in society. People infected with HIV are also often shunned by their families and victimized by violence from other community members. To help address these challenges, the DRC Integrated HIV/AIDS Project (ProVIC) partnered with *Centre de Solidarite Nationale* (CSN), a legal aid organization in Kinshasa, in April 2012. Partners like CSN helped ProVIC reach almost 100 eligible adults and children with protection and legal aid services in the project’s third year alone.

Protecting the rights of PLWHA is just one component of ProVIC’s holistic mission to support the most vulnerable groups affected by HIV/AIDS. The project has helped build an extensive local network to ensure this support starting at the community level—including among ProVIC’s 196 Champion Community self-help groups for PLWHA. PLWHA identified as needing legal support during self-group discussions are referred to CSN’s lawyers, who then help individuals navigate cases ranging from sexual and gender-based violence (SGBV) and false legal accusations to inheritance disputes and child abuse.

As many of CSN’s clients have little knowledge of their legal rights, their lawyers conduct outreach and trainings with ProVIC’s self-help groups on subjects like child protection and SGBV. PLWHA are also coached on how to handle discrimination and resolve their cases through mediation, when possible. Cases that proceed to court are fully tracked by CSN’s lawyers, who support their clients at every stage—even advocating for critical access to health care and antiretrovirals for imprisoned PLWHA. CSN has also planned a series of capacity-building workshops with Kinshasa police to address continued concerns around mishandled and uninvestigated cases.

Papa Pedro is just one example of community-driven success in mobilizing local resources to support PLWHA. An elderly PLWHA, Papa Pedro had been victimized by continued, targeted physical violence before being imprisoned for four months on false accusations. Local nongovernmental organization AMO-Congo, a ProVIC grantee, then referred him to CSN lawyer Adrien Kangumba, who facilitated his release after several court appeals. CSN is now helping Papa Pedro pursue charges against those who falsely accused him.

For Papa Pedro and thousands of other PLWHA across five provinces, ProVIC champion communities mobilize diverse community stakeholders and resources—from pastors to police, and from village chiefs to courts—to sensitize them to issues in their communities, transform harmful attitudes around HIV/AIDS, and find sustainable solutions to combating stigma and discrimination against PLWHA.



SUCCESS STORY

A voice for everyone: Empowering orphans and vulnerable children through child-to-child groups

In the western province of Bas-Congo, ProVIC helps build the capacity of child-to-child groups to provide care and support to orphans and vulnerable children



Above: Kasing Nginbi, a member of the Louange child-to-child group, reflects on positive changes he has witnessed since joining the group. Below: A child-to-child group gathers outside a ProVIC-supported community voluntary counseling and testing center in Kinzau Mvuete, Bas-Congo, to promote HIV prevention services.



In the Democratic Republic of Congo (DRC), children affected or orphaned by HIV/AIDS are often vulnerable to stigma, discrimination, and illness. The DRC Integrated HIV/AIDS Project (ProVIC) is responding to this challenge, supporting more than 8,300 orphans and vulnerable children in four provinces to date through a family-centered approach to myriad care and support activities. This includes child-to-child groups, which create a safe space for children to both voice and address their concerns—including by empowering them as change agents among their families and communities.

In the Champion Community of Kinzau Mvuete in the western province of Bas-Congo, a child-to-child group called *Louange* (meaning ‘prayers’) has fueled positive changes in knowledge and attitudes around HIV/AIDS and other health and social issues. These 11- to 18-year-olds—some orphaned or affected by HIV/AIDS, others infected themselves—meet at least monthly to share concerns ranging from gender-based violence and HIV prevention to school fees and sanitation.

Ngome Ngome is the president of a ProVIC-supported self-help group for people living with HIV/AIDS whose children all became members of *Louange*. He has since noticed dramatic changes: “Before the start of this group, people in the area had little awareness of HIV, and orphans and vulnerable children were neglected. Members of the group have received a lot of capacity-building on how to live in the community. It is clear they really understand the importance of the subjects discussed in their group.” *Louange’s* members are now doing better in school, enjoy stronger relationships with their parents, and feel less anxious thanks to the support network forged with their *Louange* peers and facilitators. With a stronger sense of their rights and roles in society, they also report feeling empowered to speak confidently to their friends, families, teachers, and pastors about what they learn in *Louange*.

Kasing Nginbi, 17, has never missed a *Louange* meeting. He especially likes the drama and role play the facilitator uses to help youth learn about HIV/AIDS and keeping safe: during one such role play, the facilitator demonstrated condom use to the group and invited discussion on HIV prevention. Kasing went home and told his parents, who were initially angered by what seemed an inappropriate subject. But he persevered, and with the facilitator’s support, eventually changed their attitudes.

With newfound confidence and better grades in school, Kasing is now thinking of becoming a community volunteer or facilitator himself. His story is just one example of how ProVIC-supported champion communities are catalyzing stronger links between children, their families, and communities, increasing awareness around HIV/AIDS, and fostering sustainable, community-driven solutions to diverse development concerns.

Photos: ProVIC/International HIV/AIDS Alliance

October 2012

SECTION 6: PROVIC YEAR 3 SHORT-TERM TECHNICAL ASSISTANCE DASHBOARD FOR FOLLOW-UP

Traveler/Dates	Statement of work	Key recommendations	What needs to happen?	ProVIC lead responsible technical team	By when?	Status/Comments
Voulu Makwelebi, Georges Ntumba February 14-16, 2012	Participate in PEPFAR regional workshop on HIV prevention for MSM, Johannesburg.	Define strategy and mechanisms for reaching out to MSM and other MARPs with HIV-related services and interventions.	Work with PNMLS and PNLS to document strategy and reach out by providing specific services to MSM.	Georges Ntumba, Voulu Mindongo, Gilbert Kapila	Ongoing	Training on HIV/AIDS and STIs, and interpersonal and group communication.
LouLou Razaka April 6-May 4, 2012	Create a plan to transfer skills and knowledge to responsible parties in the champion communities. Transfer key Champion Community competencies to community members to ensure the sustainability and independence of the champion communities from reliance on outside assistance	Reorganize Champion Community Steering Committee work plans to better support Champion Community activities.	Ensure the transfer of skills and responsibilities from NGOs to champion communities.	ProVIC management team, Regional Coordinators	Guidelines Q4 Year 3; implementation Q1 Year 4, next Champion Community cycle	Reorganize work plan and individual responsibilities within the champion communities; revise plan within the six-month cycle; revise CC steering committee members; transition CC steering committee to become sustainable by encouraging registration to become community based associations; provide training in the identification and management of income-generating projects.
Elizabeth Rowley May 28-June 8, 2012	Train staff on GBV and develop a work plan and partner agreements.	Develop GBV fixed-obligation grants.	Finalize grants and seek approval.	Herbie Muzita	Q4 Year 3; Q1 Year 4, Kinshasa	Ongoing. Three fixed-obligation grants submitted to USAID in July.
		Identify champion communities where	Identify communities and initiate the "Champion	Salva Mulungo, Rianne Gay	Q1 Year 4	

Traveler/Dates	Statement of work	Key recommendations	What needs to happen?	ProVIC lead responsible technical team	By when?	Status/Comments
		gender/GBV themes can be implemented.	Men/Champion Women" approach.			
		Discuss how to ensure post-exposure prophylaxis kit availability for the eight identified GBV sites with key partners.	Work to increase the reliability and availability of kits.	Rianne Gay	Ongoing	Made an initial agreement with UNFPA to provide post-exposure prophylaxis kits.
Emery Nyanka, local consultant February 1-22, 2012	Work with grantees to develop their own OVC child protection policies.	Grantees need to adapt OVC policy framework to develop their own policies.	Each grantee has their own child protection policy in place.	Alione Badara Sow (grantees board; director: Chriss Tshibaka)	Q4 Year 3	
Paluku Bahwere, nutrition consultant March 26-April 14, 2012	Finalize national guidelines for PLWHA nutritional management. Produce a simple guide for ProVIC grantees and partners. Train nutritionists and the Care and Support team.	Complete the M&E section for the national nutritional guidelines manual with PNMLS/PNLS. Update PLWHA menu (linear programming). Support the printing and dissemination of the guidelines.	Complete M&E section of PLWHA nutritional guidelines (in close coordination with PRONANUT). Identify a consultant with linear programming experience. Print and disseminate the national guidelines.	Alioune Badara Sow	Q1 Year 4 (linear programming)	The FANTA team recommended ProVIC spearhead updating of the national PLWHA nutritional guidelines. The consultant's visit has achieved this; however, PRONANUT is now responsible for coordinating the completion of the M&E section with PNMLS/PNLS. The consultant's proposal to update the PLWHA menus is an opportunity to provide capacity-building support in linear programming to government.
Elyse Makuta Zambite, ProVIC; Jean Kabwau	Exchange visit to Burkina Faso to engage with local health	Pilot community-level referral networks with PSSP. Use as a learning	Work with PSSP to operationalize community-level referral networks.	Elyse Zambite	Q1 Year 4	Ideas shared with USAID and other key stakeholders.

Traveler/Dates	Statement of work	Key recommendations	What needs to happen?	ProVIC lead responsible technical team	By when?	Status/Comments
Sang'Abane, PNMLS; Mbwolie Nsabala Hilaire, PSSP May 23-28, 2012	administrators/practitioners in learning about effective referral systems.	site.				
Dr. Roger Likofata Basungeli, Heal Africa local consultant March-June 2012	Create home visit checklists and palliative care guides for self-help groups.	Produce and train volunteers/caregivers on palliative care guides and checklists for home visits.	Finalize a palliative care guide and have it approved for use by caregivers during home care visits.	Alioune Badara Sow	Completed	
Amandine Bollinger, regional consultant March 18-30, 2012	Seek C2C manual approval and implement a TOT. Create a French version of the manual.	Involve PLWHA in C2C groups as facilitators. Continue to train "super trainers" and finalize a French version of the manual.	Finalize manual and implement a training on C2C group facilitation.	Alioune Badara Sow	Manual Q4 Year 3	Training of "super trainers" is ongoing. Child protection will be emphasized in Year 4 activities.
Melanie Coyne September 24-October 1, 2012	Document ProVIC Care and Support success stories, including success in the broad areas where IHAA provided technical assistance in Year 3 (e.g., nutrition, palliative care).	Support links and exchanges between self-help groups and C2C groups. Cascade technical inputs to the self-help group/C2C level as needed.	Develop/Write success stories. Year 4 work plan will prioritize key activities.	Alioune Badara Sow		Addressed in the Year 4 work plan: forums being established for those involved in home-based care, self-help groups, and C2C groups; and tools training to be carried out, such as the newly developed C2C group manual for trainers and facilitators. Selected success stories will be highlighted in the annual report.
Anh Thu Hoang, Washington, DC, M&E advisor	Gain in-depth understanding of Champion Community	Continue to work with Dr. Salva Mulungo to develop tools for	Finalize Champion Community evaluation plan and tools.	Denise Ndango, Salva Mulungo, in	Q3 Year 3	Tentative plan for Champion Community evaluation developed (see next trip).

Traveler/Dates	Statement of work	Key recommendations	What needs to happen?	ProVIC lead responsible technical team	By when?	Status/Comments
February 13-24, 2012	operationalization in order to evaluate success and challenges.	Champion Community process evaluation.		coordination with Washington, DC, M&E advisor		
	Review data quality processes and observe training of partners on data cards.	Improve capacities of partners that are weak in M&E and use of Excel. Provide support to partners in their transition to data cards.	Train partners on use of data cards.	Denise Ndango	Ongoing	
Anh Thu Hoang, Washington, DC, M&E advisor June 19-July 7, 2012	Roll out a capacity development approach for M&E in Sud Kivu.	Assist with scale-up of Peer-to-Peer LCD model.	Revise LCD tools (currently being used in Kinshasa).	National M&E advisor and Sud Kivu M&E Coordinator	Q4 Year 3	In Year 4 work plan.
	Provide support to translate the health-seeking behavior study results to develop a referral network system.	Assist with development of referral network system.	Develop referral network tools and methods.	HSS Specialist	Q1 Year 4	Completed.
	Design ProVIC's Champion Community impact evaluation with the field office.	Develop overall design of Champion Community evaluation.	Develop technical design, implementation plan for baseline.	Washington, DC, M&E advisor to support national M&E advisor	Q4 Year 3	Ongoing.
		Ensure protection of beneficiaries' identity and information.	Develop project-level guidance.	National M&E advisor, with Washington, DC, support	Q4 Year 3	Completed.

Traveler/Dates	Statement of work	Key recommendations	What needs to happen?	ProVIC lead responsible technical team	By when?	Status/Comments
Kayembe Becmay May 14-20, 2012, Matadi; May 28-June 3, 2012, Bukavu	Provide TOT to provincial social workers, to in turn train social actors on the ground on proven skills and methodological approaches to protect and care for vulnerable people, with a focus on OVC.	Train service providers in ProVIC intervention sites on OVC programs and approaches.	Train all social workers in ProVIC's intervention zones.	MINAS, ProVIC	TBD with grantees	OVC training modules are produced with the support of ProVIC.
Ousmane Kere July 8-27, 2012	Train grantees and ProVIC staff on QuickBooks software.	Explore feasibility of use of same chart of accounts among grantees.	All grantees use a standardized chart of accounts.	Jean Ntumba, with Herbie Muzita	Q1/2 Year 4	This is likely not appropriate given the variety of organizations that ProVIC works with, but we will explore options.
		Put in place a backup system to secure and protect QuickBooks data in an offsite location.	All grantees back up QuickBooks data.	Jean Ntumba	Q1 Year 4	
		Use data collection forms to summarize transactions.	Grantees start systematically summarizing transactions.	Herbie Muzita, Jean Ntumba	TBD with grantees	ProVIC will likely start this in Year 4.
Matthew Breman, Project Director October 15-31, 2012	Participate in finalization of the Year 3 work plan and general project supervision.	Document ProVIC strategy through visual graphic, for increased project understanding/visibility. Better integrate family planning into ProVIC activities.	Better linkage of family planning to ProVIC services.	COP, DCOP, all technical leads	Q4 Year 3	Visual graphic has been completed/approved by USAID, and is ready for use; family planning activities have been incorporated (see quarterly and semiannual reports).

Traveler/Dates	Statement of work	Key recommendations	What needs to happen?	ProVIC lead responsible technical team	By when?	Status/Comments
Matthew Breman, Project Director April 13-29, 2012	Provide general project supervision.	Engage USAID for development of communications plan to highlight project successes as we enter final project years. Look for opportunities to increase project visibility.	Increase in-country and international visibility through conference presentations, success stories, video, etc.	COP, DCOP, all technical leads	Ongoing	Project highlighted at International AIDS Conference oral poster presentation in July 2012. Short video highlighting ProVIC innovation around PMTCT/EID,
Younne Diallo June 9-30, 2012	Support field offices in finance and administration.	Initiate use of Petty Cash Receipt Form to add extra internal control to petty cash process.	Ensure Petty Cash Manager is using correct forms.	Petty Cash Managers (Administrative Assistants)	Q1 Year 4	FACT Manager provided example of petty cash form and related training on its use.
		Finance Officer should maintain electronic records of backup procurement documents (scan paper records).	Train Office Managers on the importance of backup documentation along with new USAID procurement guidelines and codes.	Office Managers, Accountant	Q1 Year 4	FACT Manager trained Office Managers on importance of backup documentation, along with new USAID procurement and geographic codes.
		Ensure all project employee files have up-to-date CVs, timesheets, employee agreements (and modifications), scopes of work, and annual evaluations.	Train Office Managers in correct USAID and Chemonics filing procedures.	Office Managers	Q1 Year 4	FACT Manager trained Office Managers on Chemonics and USAID filing procedures.
		Office management should update the inventory tracker according to Chemonics FACT manual policies and procedures. All project property should have numbered	Train Office Managers on US government property management and ensure that identification tags are placed on all project property.	Office Managers	Q1 Year 4	FACT Manager trained Office Managers on US government property management, and asked them to update their inventory trackers.

Traveler/Dates	Statement of work	Key recommendations	What needs to happen?	ProVIC lead responsible technical team	By when?	Status/Comments
		identification tags, and support documentation for any missing items.				
Nefra Faltas June 23-July 17, 2012	Participate in grants training workshop, and develop grant agreements.	Develop grants monitoring tool for site visits.	Adapt existing M&E monitoring tool to include grants monitoring.	COP, Herbie Muzita, Denise Ndangdo	Q1 Year 4	
		Ensure strong communication.	Generate weekly list of priorities to be shared between Washington, DC, and DRC Grants Management team.	Herbie Muzita	Q4 Year 3	Ongoing.
		Strengthen financial reporting capacity.	Identify weak grantees to be placed on targeted monthly monitoring plan.	Regional Grants Managers, Finance team	Q4 Year 3	Planned for Year 4.
Sujata Rana September 3-15, 2012	Participate in Year 4 workshop planning.					Working on Year 4 work plan for submission on October 30.
Simon Mollison September 6-16, 2012	Participate in Year 4 workshop planning.					Working on Year 4 work plan for submission on October 30.
Matthew Breman, Project Director September 4-24, 2012	Participate in Year 4 workshop planning.					Working on Year 4 work plan for submission on October 30.
Emily Gikow August 26-September 15, 2012	Participate in Year 4 workshop planning.					Working on Year 4 work plan for submission on October 30.

COP: Chief of Party; DCOP: Deputy Chief of Party; FACT: Field accounting and compliance team.

SECTION 7: SUMMARY OF PLANNED ACTIVITIES FOR NEXT YEAR

The tables below provide a summary of key activities by intermediate result. For full details of next year's plans, please see the Year 4 work plan: *DRC Integrated HIV/AIDS Project, Year 4 Work Plan, October 2012 to September 2013*.

Intermediate Result 1: HIV counseling and testing and prevention services expanded and improved in target areas

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

- Reinforce access to prevention services for MARPs and other vulnerable populations.
- Increase Champion Community access to information and knowledge for behavior change that leads to increased use of HIV prevention and GBV services.
- Increase youth access to HIV prevention services.
- Create an environment in which champion communities can flourish and sustain themselves.
- Consolidate champion communities as catalysts for change in the fight against the stigmatization and discrimination of PLWHA, OVC, and their families.

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

- Provide high-quality HCT services to priority beneficiaries.
- Provide and ensure integrated management of HIV/TB co-infection at all HCT sites.
- Support the PNLs to update and apply PICT documents and norms.
- Hold HCT innovation exchange days.

Sub-IR 1.3: PMTCT services improved

- Improve access to comprehensive PMTCT services according to national norms.
- Increase promotion and uptake of pediatric counseling and testing, and improve follow-up of mothers and infants.
- Pilot and evaluate the Mentor Mothers approach to improve retention and adherence of mother-baby pairs.
- Increase the quality of PMTCT services (quality assurance/quality improvement).
- Increase linkages between maternal and child health and other program services.
- Strengthen the capacity of government at the national level to provide PMTCT services.

Sub-IR 1.4: Community- and facility-based GBV prevention and response services strengthened

- Develop the "Champion Men/Champion Women" approach in communities to strengthen the participation of men in activities against SGBV.
- Support health care providers to effectively screen for GBV in the PMTCT setting.
- Provide high-quality support services (medical and psychosocial) to SGBV survivors.
- Strengthen the capacity of national partners, intervention partners, and key stakeholders to lead efforts to address GBV, and improve management of information-sharing on GBV.

Intermediate Result 2: Care, support, and treatment for people living with HIV/AIDS and orphans and vulnerable children improved in target areas

Sub-IR 2.1: Palliative care strengthened

- Ensure that PLWHA are diagnosed early and that they receive necessary care to manage disease.
- Enable PLWHA access to services, treatment, and knowledge for themselves and their families to remain healthy.
- Enable PLWHA access to support to achieve an improved quality of life for themselves and their families.
- Support PLWHA to manage disease and understand and take steps to reduce transmission risk to others.
- Strengthen the capacity of all those involved to deliver high-quality adult care and support.

Sub-IR 2.2: Care and support for OVC strengthened

- Support families to access necessary services for their children and to access the necessary services and support to decrease their vulnerabilities.
- Strengthen OVC education and address barriers to education.
- Increase the awareness of families and other persons involved in child protection and children's rights and reinforce child protection and children's rights.
- Strengthen OVC capacity to deal with reproductive health and environmental issues.

IR 3: Strengthening of health systems supported

Sub-IR 3.1: Capacity of provincial government systems supported

- Strengthen referral and counter-referral systems.
- Support government's supervisory role at all levels.
- Build the capacity of health care providers.
- Support commodity management in health zones.
- Support the PNMLS in development of standards and guidelines on community approaches.
- Reproduce and disseminate tools, manuals, and policy documents associated with ProVIC's interventions.
- Conduct integrated supervision.

Sub-IR 3.2: Capacity of NGO providers supported

- Strengthen the organizational capacity of partner NGOs.

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

- Strengthen ProVIC's M&E system through ongoing coordination with other technical areas.
- Provide technical assistance for M&E activities to the PNMLS, PNLS, and MINAS at the national and provincial levels.
- Strengthen MINAS M&E systems through joint missions and technical assistance in developing a national OVC database.
- Build implementing partner M&E capacity.
- Build partner M&E capacity through the peer-to-peer capacity development approach.
- Improve implementing partner capacity to conduct quality improvement and provide high-quality services.
- Provide ongoing data card technical support to partners.
- Improve reporting through RDQA.

APPENDIX A: YEAR 3 RESULTS ACHIEVED AGAINST PEPFAR INDICATORS AND TARGETS

Please see the attached Excel file for this appendix.

APPENDIX B: PROVIC YEAR 3 FINANCIAL REPORT

Please see the attached Excel file for this appendix.

APPENDIX C: COMPREHENSIVE PROPERTY INVENTORY LIST

Please see the attached Excel file for this appendix.