

DRC INTEGRATED HIV/AIDS PROJECT

PROJET INTEGRE DE VIH/SIDA AU CONGO (PROVIC) YEAR 4 SEMI-ANNUAL REPORT

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TABLE OF CONTENTS

ACRONYMS AND ABBREVIATIONS	iv
EXECUTIVE SUMMARY	vi
SECTION I: PROGRESS BY TECHNICAL COMPONENT	1
Intermediate Result 1: HIV counseling and testing and prevention services improved in target areas	1
Sub-IR 1.1: Communities' ability to develop and implement prevention strategies strengthened	1
Sub-IR 1.2: Community- and facility-based HCT services enhanced	6
Sub-IR 1.3: PMTCT services improved	12
Sub-IR 1.4: Community- and facility-based gender-based violence prevention and response services strengthened	26
Key upcoming activities for Intermediate Result 1	30
Intermediate Result 2: Care, support, and treatment for people living with HIV/AIDS and orphans and vulnerable children improved in target areas	32
Sub-IR 2.1: Palliative care strengthened	32
Sub-IR 2.2: Care and support for OVC strengthened	34
Sub-IR 2.3: HIV treatment improved in target areas	36
Key upcoming activities for Intermediate Result 2	36
Intermediate Result 3: Strengthening of health systems supported	38
Sub-IR 3.1: Capacity of provincial government health systems supported	38
Sub-IR 3.2: Capacity of NGO providers improved	40
Sub-IR 3.3: Strategic information systems at the community and facility levels strengthened	41
Key upcoming activities for Intermediate Result 3	48
SECTION II. CROSS-CUTTING ISSUES	49
Administration and finance	49
Grants management	50
Environmental monitoring and mitigation activities	51

ACRONYMS AND ABBREVIATIONS

ACOSYF	<i>Association Coopérative pour la Synergie Féminine</i>
AIDS	Acquired Immune Deficiency Syndrome
ALUDROFE	<i>Association de Lutte pour la Défense des Droits de la Femme et de l'Enfant</i>
ANC	antenatal care
ART	antiretroviral therapy
ARV	antiretroviral medication
ASF	<i>l'Association de Sante Familiale</i>
BCZS	<i>Bureau Central de Zone de Santé</i>
C2C	child-to-child
CAD	<i>Club des Amis Damien</i>
CDC	US Centers for Disease Control and Prevention
CEMAKI	<i>Centre Maman Kinzambo</i>
CPCC	<i>Comite De Pilotage Des Communautés</i>
CS	<i>Centre de Santé</i>
CSR	<i>Centre de Santé de Référence</i>
CSW	commercial sex worker
DIVAS	<i>Division des Affaires Sociales</i>
DOD	US Department of Defense
DRC	Democratic Republic of Congo
EGPAF	Elizabeth Glaser Pediatric AIDS Foundation
FFP	Fondation Femme Plus
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
IR	Intermediate Result
M&E	monitoring and evaluation
MARP	most at-risk population
MINAS	<i>Ministère des Affaires Sociales</i>
MNCH	maternal, newborn, and child health
MOH	Ministry of Health
MSM	men who have sex with men
NACS	Nutrition Assessment, Counseling, and Support
NGO	nongovernmental organization
OVC	orphans and vulnerable children
PATH	Program for Appropriate Technology in Health
PBF	performance-based financing
PEP	post-exposure prophylaxis
PEPFAR	US President's Emergency Plan for AIDS Relief
PITC	provider-initiated testing and counseling

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>
PNSR	<i>Programme National de Santé de la Reproduction</i>
ProSIFU	<i>Projet SIDA Fungurume</i>
ProVIC	<i>Projet Intégré de VIH/SIDA au Congo</i>
PSI	Population Services International
PSSP	<i>Progrès Santé Sans Prix</i>
QA/QI	quality assurance/quality improvement
RDQA	routine data quality assurance
ReCos	<i>relais communautaires</i>
RNOAC	<i>Réseau National des Organisations d'Assise Communautaire</i>
SBCC	social and behavior change communication
SGBV	sexual and gender-based violence
STI	sexually transmitted infection
TB	tuberculosis
UNFPA	United Nations Population Fund
URC	University Research Co., LLC
USAID	US Agency for International Development
VCT	voluntary HIV counseling and testing
WHO	World Health Organization

EXECUTIVE SUMMARY

This semi-annual report covers the reporting period from October 2012 to March 2013. During this reporting period, ProVIC's performance against targets was good overall. In particular, within PMTCT activities, ProVIC reached 98% of its semi-annual target of pregnant women reached with counseling and testing services. Of these, 533 were identified as HIV positive and 89% were placed on antiretroviral prophylaxis or on ART for life. During this period, ProVIC also worked intensively on establishing models for quality assurance and quality improvement by piloting "Improvement Collaboratives" within four maternities in Kinshasa, which contributed to, among other improvements, increased participation of male partners, of whom 1,797 were tested and 2.9% were found to be HIV positive. Equally, ProVIC established PMTCT Mentor Mothers in six sites in Kinshasa, Katanga, and Province Orientale.

ProVIC's counseling and testing activities responded to earlier USAID technical recommendations by improving targeting of key populations to better identify and refer HIV-positive individuals, which reflects a more cost-effective use of PEPFAR resources. In all provinces, ProVIC tested HIV-positive individuals at a rate higher than rates reported in the 2011 *Programme National de Lutte Contre le VIH/SIDA* (PNLS) sero-surveillance study and the 2007 Demographic and Health Survey.¹ In Bas-Congo, ProVIC's HIV testing rate was 5.3% (versus 3% for PNLS); in Katanga, the rate was 7% (PNLS, 4.5%); Kinshasa was 4.4% (PNLS, 2.9%); Orientale was 5.9% (PNLS, 4.2%); and Sud Kivu was 2.2% (PNLS, 1.3%). In total, 108,678 individuals were tested for HIV which represents a 99% achievement against the semi-annual targets. Of those tested 5,297 tested positive. These results are indicative of successful community mobilization efforts through Champion Communities (CC) as well as better targeting and motivation of key populations to seek HIV testing services.

ProVIC's care and support activities, which previously focused on sustainable community-based interventions, underwent a transition toward integrated care within existing ProVIC-supported health facilities. This transition is on track as represented by the transition of cotrimoxazole from community-level distribution to health facility distribution, where 80% of ProVIC's people living with HIV/AIDS (PLWHA) beneficiaries received cotrimoxazole. Further, ProVIC improved its rate of tuberculosis (TB) screening for PLWHA, from 14% for FY12 to 68% in FY13, due to a concentrated emphasis on TB screening in both self-help groups and in health facilities.

In terms of OVC care and support, ProVIC has exceeded its annual target by providing educational and/or vocational training to 2,092 OVC (target: 1,300) due to better identification of OVCs in need and the increased ability to negotiate scholarships with schools. ProVIC is also on track to meet targets in terms of one care service, psychosocial support, clinical care, and health care referrals for children.

¹ Ministère du Plan, Macro International, Inc. *Demographic and Health Survey 2007: Democratic Republic of Congo*. Calverton, MD: Ministère du Plan and Macro International, Inc.; 2008.

ProVIC's health systems strengthening support shifted to support health zone management structures to improve coordination, supervision, and communication between health zone management teams and the health facilities, particularly US government-supported facilities.

In late February 2013, the US Agency for International Development (USAID) in the Democratic Republic of Congo formally announced the US President's Emergency Plan for AIDS Relief (PEPFAR) "Strategic Pivot" to US government partners, which clearly focuses programmatic implementation around the *Projet Intégré de VIH/SIDA au Congo* (ProVIC) prevention of mother-to-child transmission of HIV (PMTCT) Platform in the priority provinces of Kinshasa, Katanga, and Orientale. PEPFAR also laid out its vision for the continuum of treatment, care, and support to PMTCT sites, with linkages to community structures.

In line with this change in PEPFAR strategy, ProVIC also had to begin the process of realigning its core activities to align to a "PMTCT Platform" and the new vision of the Strategic Pivot. The transition to the new vision of the Strategic Pivot was achieved through a consultative work-planning workshop and resubmission of its FY13 work plan and statement of work. It is anticipated that these changes will restructure ProVIC to respond to PEPFAR's changing strategy and ProVIC will demonstrate its capacity to rapidly adjust and meet new global objectives and specific targets.

This report represents reporting against the scope of work as outlined in original ProVIC's contract and the workplan submitted prior to the Strategic Pivot. In spite of this, results during this reporting period demonstrate that the project is well-positioned to report against the new standard of the Strategic Pivot, including the acceleration of PMTCT sites, integration of antiretroviral therapy (ART), including pediatric ART, as well as new approaches to OVC education support. The PMTCT results, the improved targeting of populations for HIV testing services and the increased number of PLWHAs being served in health facilities will all contribute to the PMTCT platform focus of the Strategic Pivot.

SECTION I: PROGRESS BY TECHNICAL COMPONENT

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

The changes associated with the US President's Emergency Plan for AIDS Relief (PEPFAR) Strategic Pivot, which were first announced in late February 2013, will significantly reorient Champion Community and HIV counseling and testing (HCT) activities. However, during the reporting period, community mobilization initiatives implemented using the Champion Community approach have played a key role in raising awareness about HIV/AIDS prevention and support.

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

Activities and achievements

Community engagement has empowered families and community members to openly discuss HIV/AIDS and related issues, and it has increased communication at the community level around sexual health. Promotion of healthy behaviors such as abstinence, delayed first sexual intercourse, and use of condoms has contributed to the ability of communities to effectively prevent HIV. Specific examples of the success of the Champion Community model include the following:

- More than 220,056 people reached with HIV-related prevention messages through interpersonal communication, peer education, and door-to-door awareness campaigns.
- 43,488 members of key populations trained in sensitization and peer education skills through existing key population networks in the five target provinces.
- 58,063 youth reached with abstinence messaging through youth groups and youth-focused events.
- 90 people trained in communication skills for behavior change, specifically in relation to HIV prevention and family planning.
- 175 key population members trained in peer education.
- 735 members of *Comite De Pilotage Des Communautés* (CPCCs—Champion Community Steering Committees) trained in the Champion Community approach.

Activity 1: Reinforce and strengthen access to prevention services for key populations, including most at-risk populations (MARPs) and other vulnerable groups.

Key achievements under this activity area include:

- Revising the peer educator training module: ProVIC revised the training module for MSM and other key populations to improve prevention and treatment activities. ProVIC will share the module with *Programme National de Lutte Contre le VIH/SIDA* (PNLS) for comment and input before finalizing and distributing it to partners that work with these populations.
- Reinforcing peer education capacity within key populations: ProVIC organized peer educator workshops focused on at-risk populations in the five provinces, reaching 175 members of key populations (CSWs and MSM) to build the capacity of these groups in social and behavior change communication (SBCC). These beneficiaries are now well equipped to avoid harmful or risky behaviors and empowered to employ responsible, healthy practices. ProVIC established focal points for MSM and CSWs at each testing site, ensuring the consistent presence of peer educators. There are now eight networks of MSM and CSWs that organize HIV prevention activities among peers. These activities include:
 - SBCC reinforcement.
 - Sensitization of female sexual partners of MSM and other lesbian, gay, bisexual, and transgender individuals.
 - Promotion of proper use of condoms and water-based lubricants.
 - Promotion of safer sex and healthy behaviors.
 - Voluntary HIV counseling and testing (VCT) referral and the proper treatment of sexually transmitted infections (STIs).
 - Proper care of anal infections.
 - Orientation to self-help groups for psychosocial support of seropositive MSM and CSWs.
 - Risk awareness and vulnerability mapping.
- Mapping HIV risk and vulnerability and raising risk awareness: For improved planning and coordination of activities of key populations and other vulnerable groups, the project worked in collaboration with the health zones, CPCCs, *relais communautaires* (ReCos), peer educators, youth, students, and representatives from religious and health groups to develop HIV risk and vulnerability mapping. This mapping exercise has enabled the champion communities to:
 - Establish a list of categories of the groups vulnerable to HIV:
 - Identify high-risk practices and behaviors within their communities.
 - Identify Champion Community priority actions and targets for the fight against HIV.
 - Identify areas and venues frequented by key populations.
 - Risk mapping was conducted in the following health zones (champion communities are included in parentheses):
 - Sud Kivu: de Bagira (de Kasha); d'Ibanda (de Malkia); Nyatende (de Igoki and de Nyatende); and de Uvira (de Kalundu, Kimanga, and de Mulongwe).
 - Province Orientale: Kisangani: de la Tshopo (de Pumuzika and de Malkia); de Makiso (de Neema); and de Kabondo (de Kabondo).
 - Bas-Congo: Lukula (de Lukula and Patu); de Boma (de Kalamu); and de Moanda (de Moanda).
 - Katanga: All champion communities.

- Kinshasa: Risk mapping was not conducted in Kinshasa, as it was planned at the same time that the Strategic Pivot was announced.
- Reproducing promotional materials and distributing to peer educators and community workers: To increase visibility, awareness, and motivation of trained peer educators, ProVIC assembled promotional materials, including bags, t-shirts, caps, and pens, and will distribute them to peer educators in Q3.

Before ProVIC, it was not easy to express ourselves in society. Today, we not only have been trained among other members of the community to be involved in the fight against HIV and AIDS, but more importantly, we are more confident, empowered, and valued through the sensitization and awareness work that we do for the benefit of the whole community.

Vovo, MSM Neema leader, Kisangani

Activity 2: Increase Champion Community access to information and knowledge of behavior change that leads to increased use of existing HIV prevention and gender-based violence (GBV) services.

With project support, champion communities developed action plans to address behavior change promotion and implemented numerous activities, including training peer educators, community outreach agents, and members of various CPCCs in access to information.

ProVIC employed various forms of outreach, including interpersonal communication, social mobilization, and advocacy to reach different demographic groups, including students, youth, married women, pregnant women, teenage mothers, traders, and truck drivers. Sensitive messaging was integrated into communication around HIV, family planning, and sexual and gender-based violence (SGBV) in the champion communities, with a strong focus on PMTCT

during Q2. This messaging stressed the importance of involving male partners of pregnant women to ensure effective and lasting impacts of PMTCT services.



Sensitization session and condom distribution for motorcyclists and Tolékistes at the African Soccer Cup of Nations championship, Loboko Pete site in Neema Champion Community. (Photo: ProVIC Kisangani)

In order to support and respond to the needs of *Programme National Multisectoriel de Lutte Contre le VIH/SIDA* (PNMLS) and the PNLs, ProVIC spearheaded activities in all five provinces as part of World AIDS Day on December 1, 2012. The activities were consistent with the theme of World AIDS Day: “Getting to Zero: Zero new HIV infections; Zero discrimination; Zero AIDS related deaths.” In accordance with PNMLS guidance, the project continued the activities throughout the month of December.

After the training, we learned a lot about how to prevent HIV, and the African Cup of Nations event has helped us to reach a greater number of our peer bikers, who are very vulnerable and who were very receptive of HIV messages and condom use. We are pleased to have raised our awareness.

Tamabele, community volunteer, Kabondo Champion Community

As I am the leader of the group, CSWs listen to me carefully and during sensitization campaigns, organized during the African Cup of Nations, many CSWs have agreed to be tested. They also suggested that we regularly organize the sensitization in our “ghettos” and together we should advocate to have access to STI treatment.

Baby, committee member and CSW leader, Kabondo Champion Community

Activity 3: Improve access of youth to HIV prevention services.

To reduce the vulnerability of youth to HIV/AIDS, ProVIC worked with youth groups through clubs and youth centers, equipping them with knowledge and skills to deal with issues related to HIV/AIDS, help them better assess risk factors, and develop action plans to minimize the risks. ProVIC organized bimonthly meetings with youth groups in certain champion communities, including seven in Mbankana Champion Community, three in Mont Ngafula Champion Community, and five in Biyela Champion Community, each of which had a minimum of 40 participating youth. Activities reinforced the following behaviors to reduce and eliminate the risk of contracting HIV: abstinence, avoidance of contaminated objects, monogamy, use of condoms and other contraceptives, avoidance of harmful substances such as alcohol, tobacco, and drugs, and other practices that reinforce sexual health.

These activities have utilized youth focus groups and peer education activities to distribute male and female condoms and promote abstinence, monogamy, delayed first sexual intercourse, and use of contraceptives among youth.

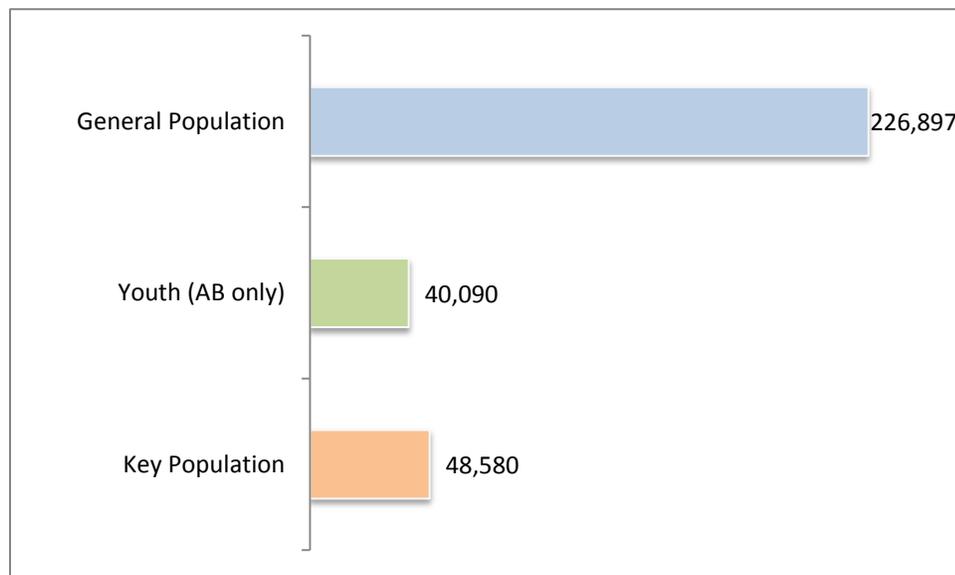
In Q3, in line with the directives of the Strategic Pivot, ProVIC’s youth interventions will concentrate on health facilities with high HIV seropositivity rates to provide comprehensive prevention activities for young people.

To ensure the effectiveness of prevention activities among young people aged 15 to 24 years, ProVIC will employ peer education and advocacy activities to impart practical knowledge and HIV-related life skills with youth in schools, churches, youth centers, local organizations, and communities. ProVIC will also support referrals and counter-referrals to health facilities for counseling and testing for STI, HIV, and family planning services. In addition, the project will emphasize the involvement of young men in PMTCT-focused HIV prevention activities and the promotion of gender equality, including informing beneficiaries of relevant laws and policies. For youth who can be categorized as orphans and vulnerable children (OVC), being a member of a child-to-child (C2C) group is another way for ProVIC to reinforce healthy behaviors and improve life skills.

ProVIC has reached 61,119 youth with HIV prevention messaging, and abstinence messaging has focused on youth older than 15 years. A total of 85% of these youth were between the ages

of 15 and 24, and 51% were girls/women. The following figure illustrates prevention messaging to youth as compared to other key populations.

Figure 1. Populations reached with prevention messages.



Activity 4: Transform/Consolidate champion communities into catalysts for change in the fight against the stigmatization and discrimination of people living with HIV/AIDS (PLWHA), OVC, and their families.

As a result of the PMTCT Strategic Pivot, this activity has been revised to focus on the development of an exit plan for the champion communities that are not within the geographic location of health facilities providing PMTCT services. The plan includes specific instructions to ensure a smooth transition period and the continuity of services and support to PLWHA and OVC by promoting these activities in the local health system and throughout the respective health zones.

The transition plan will utilize local self-help and C2C groups, and it will consist of four phases: preparatory, execution, support, and phase-out. In the preparatory phase, ProVIC will review the structure of champion communities and develop internal rules and procedures, establish intervention areas within the health zones, and plan transition activities. In the execution phase, the project will organize meetings with the ECZS to reinforce visibility of champion communities and work to gain official recognition and integration of champion communities into the local health systems. Once this has been established, ProVIC will continue to support the champion communities during the third phase to ensure a sustainable phase-out of the project's involvement.

Challenges and proposed solutions

Challenges	Proposed solutions
Inactivity of some trained community outreach agents and peer educators in champion communities.	Encourage <i>Bureau Central de Zone de Santé</i> to accompany steering committees in follow-up with community outreach agents and peer educators.
Lack of a consistent mechanism among US government implementing partners to provide incentives and motivate Champion Community members and other community outreach agents.	Work with US government implementing partners to define a common mechanism aimed at providing incentives to steering committee members and community workers.

Key upcoming activities

- Implement the transition toward the vision of the Strategic Pivot, which entails ending support to champion communities that do not link directly to a ProVIC-supported PMTCT site. It also includes a change in strategy in those champion communities where ProVIC is supporting PMTCT. In such cases, Champion Community activities will be re-oriented toward PMTCT messaging and adherence.
- Organize counseling sessions for MARPs to reduce their risks of HIV infection and transmission.
- Organize sensitization activities and events for key populations in the provinces.
- Ensure promotion and distribution of male and female condoms and lubricants for key populations, youth, and the general population.
- Design and develop key messages tailored to PMTCT and the involvement of male partners.
- Organize sensitization and involvement of male partners through key HIV prevention messages for better integration of PMTCT, HCT, and stigma reduction.
- Organize community-based meetings with leaders in communities around targeted sites for the promotion of PMTCT services.
- Conduct sensitization sessions on sexual risk reduction that are adapted to youth needs.
- Work with health zone teams to seek the recognition of champion communities as local organizations involved in HIV prevention activities.

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

Activities and achievements

ProVIC continuously seeks to improve targeting of HCT services through supportive supervision with partners and better identification of sites in which to propose mobile testing. In this reporting period, ProVIC improved considerably its targeting in response to earlier USAID recommendations to do so. Specific data is analyzed at the end of this section.

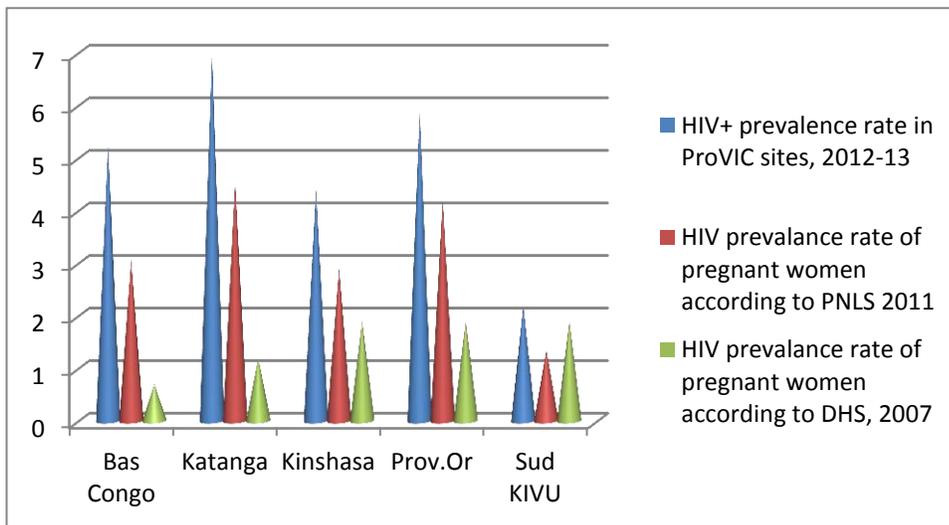
In all five provinces, three types of counseling and testing took place: mobile HCT, community and integrated HCT, and Provider Initiated Testing & Counseling (PITC). Participation in World AIDS Day activities and daylight and moonlight HCT demonstrates the willingness and demand

of the general public to know their HIV status when they are aware of the support services available after testing.

As emphasized by the PEPFAR strategic pivot, going forward ProVIC strengthen referrals and linkages so that all counseling and testing services are followed by a continuum of care in the form of treatment and support. ProVIC has strengthened its referral and counter-referral system to ensure that all counseling and testing, both mobile and stationary, are linked to follow-up care after testing. This initiative to reinforce the referral system in the five target provinces has consisted of advocacy to promote the importance of referrals and counter-referrals, trainings for partners to ensure all care providers understand the procedures of the referral system, and the introduction of forms/tools for providers to fill out to track referrals and make sure all patients who are tested are referred to the appropriate post-testing care service.

Based on the PEPFAR strategic pivot announced in February 2013, counseling and testing of all kinds (PITC, mobile, PMTCT, community-based) in South Kivu was discontinued. In Bas Congo, which is not a priority province for PEPFAR going forward, but is still under analysis, ProVIC is now focusing all counseling and testing activities within health facilities, which resulted in the closure of the mobile HCT testing service via the local partner PSSP, although mobile services were provided by health facilities under the supervision of health zones and with ProVIC support.

Figure 2: Seroprevalence rates by province



In this graphic it is clear to see that ProVIC is targeting and testing at a higher rate than the rates recognized by the PNLS and the USG funded DHS from 2007 (the last time this study, considered by many to be the most accurate, was conducted). In ProVIC sites, Katanga has the highest rate of seropositivity with 7%, followed by the Eastern Province with 5.87%, and then Bas Congo with 5.25%. Kinshasa, with a high population density, has a rate of 4.55%.

Consistent with best practices and with the strategic pivot, the project linked HCT with treatment and support, which served to provide crucial continuum of care for clients who tested positive for HIV. ProVIC continues the focus on strengthening its referral system to service facilities.

This initiative to reinforce the referral system in the five target provinces included advocacy to promote the importance of referrals and counter-referrals, training partners to make sure that all care providers understand the procedures of the referral system, and an orientation to client tracking forms.

The PEPFAR strategic pivot required ProVIC to realign its priorities among the sites it supports. The project selected two key partners to continue with provision of mobile HCT services to CCs and PMTCT sites in priority provinces: World Production in Katanga and Progress Santé Sans Prix (PSSP) in Kinshasa. In Bas Congo and Orientale Province, mobile HCT will be provided by PMTCT health workers for key populations in the catchment area CCs.

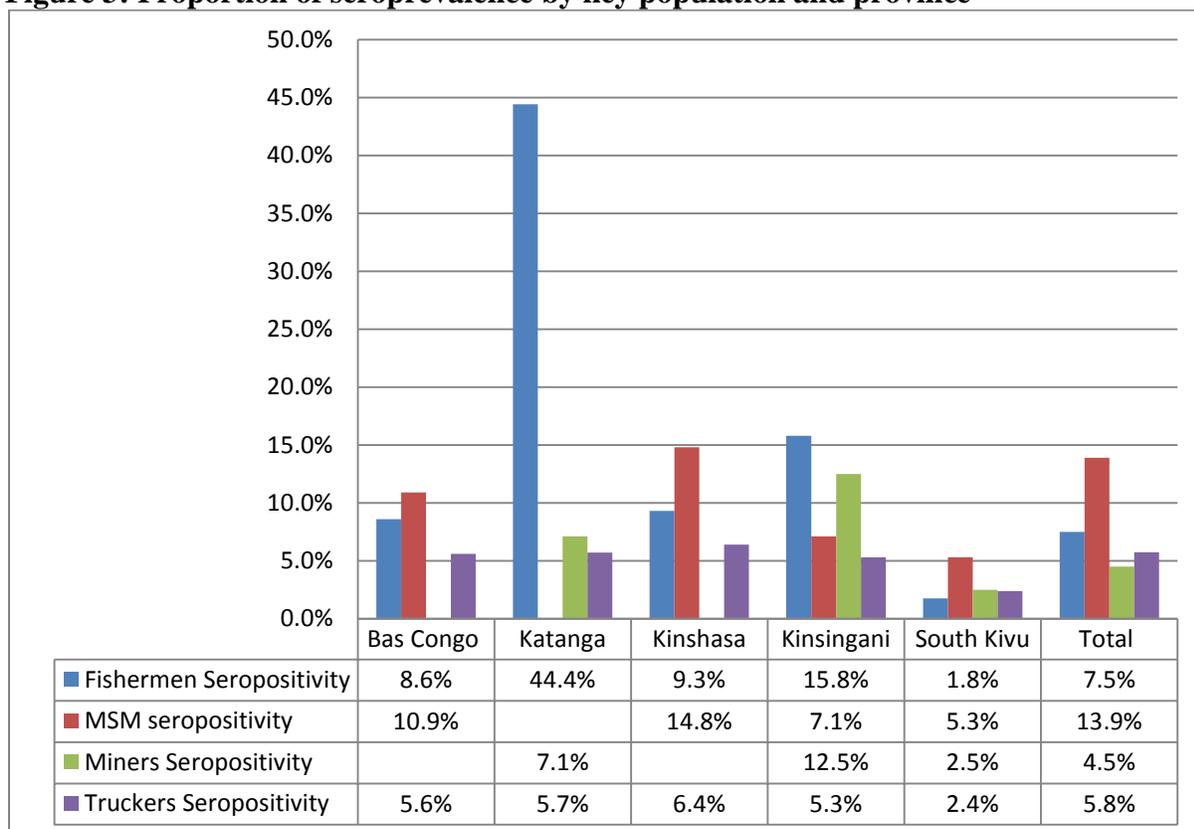
Unfortunately, the pivot also meant reducing its investments in South Kivu and Bas Congo. PITC and mobile testing will continue, but HCT for non-priority groups have been discontinued.

Table 1: Testing rates by gender and province

Male and Female Participants in HCT		
	Male	Female
Bas Congo	6,596	10,124
Katanga	10,557	13,982
Kinshasa	22,517	27,136
Oriental Province	617	2,037
Sud Kivu	5,658	8,532
Total	45,945	61,811

This table reveals that women participate in testing and counseling at a higher rate than men. However, ProVIC continues to reach out to men, both those in key populations and those who are partners to women in PMTCT programs. Note that testing in Kinshasa occurred at a higher rate than anticipated to avoid expiration of Determine test kits, a large batch of which was dated for expiration in March 2013. Although the Kinshasa testing was accelerated, it was done so ensuring health zone participation and referrals for HIV+ individuals.

Figure 3: Proportion of seroprevalence by key population and province



Although data sets were small, they do indicate that there is a need for prevention and treatment among members of key populations. In every case the positive rate of these populations exceeded the rate for the general population nationally. As ProVIC is doing, these interventions must be tailored to the lifestyles and availability of the members themselves.

Activity 1: Provide high-quality HCT services to 220,000 priority beneficiaries.

ProVIC provided counseling and testing services to 108,678 individuals, including 11,448 sex workers and 2,116 MSM. During the course of the reporting period, ProVIC improved on its coordination with health zones by coordinating the movement of the mobile HCT service. ProVIC also improved on its referral systems by adding health staff from local hospitals to the mobile outreach teams to strengthen the link between the testing service and immediate following care, support and treatment.

ProVIC provided technical and financial support to the following seven workshops, five of which took place in Kisangani:

- Training in counseling and testing services for 23 volunteer care providers from six PMTCT and HCT structures in target zones in Kisangani.
- Training in management of biomedical waste for 30 care providers in Kisangani. Two of these providers were from Pumuzika and two were from Fondation Femme Plus (FFP).
- Training for 24 providers (including 13 women) in the finger-prick technique and rapid test results. Two trainees were from Pumuzika and three were from FFP.
- SGBV support training for 17 providers, including GBV screening, in Kisangani. Two were from Pumuzika.
- Training in family planning with *l'Association de Sante Familiale* (ASF)/Population Services International (PSI) for 16 providers from ProVIC sites and two from Pumuzika sites in Kisangani.
- Training in Bas-Congo on proper and effective use of PIMA™ Analysers for PMTCT sites, and PLWHA biological monitoring support. A total of six laboratory technicians received training under the supervision of the provincial PNLs laboratory supervisors.
- Training in biomedical waste management for 30 people (including 13 women) in Katanga.
- Training of 146 care providers to develop their capacity to offer high-quality services in Bas-Congo, Katanga, and Province Orientale.



A moonlight testing organized on World AIDS Day, December 1, 2012, Bandalungwa commune, Kinshasa.

ProVIC took the following steps to ensure high-quality HCT services to its beneficiaries under Activity 1:

1. Distribution of commodities, including laboratory tests: ProVIC distributed equipment to PMTCT partners, VCT sites, and VCT/PITC sites according to their needs. There were no stockouts, which allowed all HCT and PMTCT sites to operate without interruption.
2. Provision of HCT on World AIDS Day 2012: ProVIC conducted counseling and testing in coordination with its partners on World AIDS Day in all five provinces.
3. Reproduction of data collection and reporting tools: ProVIC reproduced a data collection and reporting toolkit and provided support to care facilities in accordance with their needs. The toolkit consists of forms and materials needed to track and report data relevant to care facilities, forms to track appointments and the number of patients receiving services, laboratory registries, and forms to record counseling services provided.

Activity 2: Support the PNLs to update and apply PITC documents and norms.



HCT mobile testing in Pumuzika Champion Community.

Having received support from ProVIC, the vast majority of health centers are now using PITC. More than 600 people received counseling and testing in health zones during the reporting period, approximately 75% of whom were women. Roughly 7% tested HIV positive, and they were referred for treatment and care services.

The project has postponed workshops for PITC with the PNLs until Q3, when their experts will be available.

However, ProVIC was able to move forward with PITC by providing the following technical assistance:

- Integration of PITC activities in new PMTCT sites in Katanga and Kisangani
- Monitoring and technical support for VCT and PITC
- Biomedical waste management support
- Mobile HCT orientation for key populations using maps developed at various PMTCT CC sites
- Promotion of efficient system of referrals and development of counter-referral system
- Workshops in intervention sites to assist providers to use management tools properly, filing and record keeping, activity reporting, and other tasks.
- Deploying providers to HCT mobile teams

Challenges during the reporting period and proposed solutions.

Challenges	Proposed solutions
No national guidelines and protocols on PITC.	Support a PITC guidelines workshop in Q3.
Weak understanding of PITC within facilities.	Train providers in PITC in Q3.
Weak understanding of the finger-prick technique and its use within new facilities offering PMTCT services in Bas-Congo.	Re-evaluate providers and provide refresher training.
Weak data reporting on biomedical waste management.	Intensify assessment and follow-up of biomedical waste management during all technical supervision and field visits.

Sub-IR 1.3: PMTCT services improved

Overview

During Q1, ProVIC supported the implementation of PMTCT activities at 43 sites including health centers and general reference hospitals. ProVIC’s original PMTCT annual target for FY13 was to counsel and test 50,000 pregnant women for HIV and provide 1,008 HIV-positive pregnant women with ARVs to reduce the risk of MTCT. To this end, ProVIC counseled and tested 24,496 women (at 98 percent of the semi-annual target) and provided 472 women with ARVs to reduce the risk of MTCT (at 85 percent of target).

During the reporting period, ProVIC continued to use innovative approaches to ensure quality services for PMTCT. This included piloting URC’s “Improvement Collaborative” methods for quality improvement and quality insurance in Kinshasa maternities, and piloting EGPAF’s Mentor Mothers approach in using trained peer counselors during the PMTCT service delivery process. The Mentor Mothers pilot began during the second quarter of this project year. The team also continued to conduct routine, targeted supervision visits to further improve service quality and site performance.

During the reporting period, ProVIC collaborated actively with the MOH through PNLs, PNSR, D10 (the 10th direction of the MOH), and provincial health teams to ensure the alignment of project-supported PMTCT activities with national standards, and to strengthen governmental leadership of HIV activities. ProVIC also worked closely with other PEPFAR implementing partners and the Global Fund to harmonize interventions on ground.

ProVIC’s PMTCT activities are also aligning with the strategic pivot, which places the PMTCT platform at the center of ProVIC’s activities going forward. From the perspective of PMTCT, the strategic pivot encompasses the following priorities:

- Reinforcing health facilities by providing support to health zones around data validation, supply chain management, and the strengthening of referral systems between community- and facility-based activities in these health zones.
- Quality Improvement of PMTCT services provided to pregnant women and their families through a complete package of continuum of HIV care services, and using PMTCT as the entry point for comprehensive services. These include: planning for ART for HIV-positive

women and their families, including the startup of Option B+ activities in select PMTCT hubs; TB/HIV co-infection care and support; cotrimoxazole prophylaxis; psychosocial support (through self-support groups); services to help HIV-positive women improve treatment adherence and live positively with their families; and OVC care and support.

- Progressive extension of PMTCT activity coverage in already project-supported health zones, in order to reach at least 85 percent coverage in each supported health zone.
- Possible extension of PMTCT activities to *new, higher*-HIV prevalence health zones, in order to reach a greater number of HIV-positive pregnant women and reach the greatest number of families and individuals with a complete package of PMTCT services.

The strategic pivot has shifted ProVIC's emphasis squarely onto PMTCT. The ProVIC PMTCT component will now have a key role in coordinating integrated prevention activities (e.g., sensitizing and testing), as well care, with the ultimate goal of creating an HIV-free generation in the DRC.

These changes have required updates to ProVIC's planned PMTCT activities for 2013. During the reporting period, ProVIC therefore primarily focused on improving the quality of services provided in currently project-supported health zones while at the same time identifying new health zones and PMTCT sites. Standard criteria, such as the prior existence of PMTCT services, seropositivity levels in the surrounding health zone, and the number of pregnant women in the catchment area, are being used to select new project-supported sites.

During this reporting period, ProVIC initiated a process for identifying new sites and reassessing existing sites. Of ProVIC's 44 existing PMTCT sites, 13 sites will be discontinued in the coming months due to their low seropositivity of HIV-positive pregnant women and/or presence in a non-PEPFAR priority province. After conducting needs assessments, ProVIC's PMTCT team has also identified 44 potential new PMTCT sites. These public and private health facilities, which will be introduced gradually, are spread across 25 existing (i.e., already project-supported) health zones, and across seven new health zones in Kinshasa, Orientale, and Katanga provinces. Accounting for these changes, this makes a new estimated project total of approximately 75 PMTCT sites.

Activities and achievements

Activity 1: Improve access to comprehensive PMTCT services according to national norms in 43 current ProVIC sites.

During the first quarter, ProVIC continued to provide HIV-positive pregnant women and their families with high-quality services, including prevention, care, support, and treatment. ProVIC continued to articulate and strengthen the integration of services to ensure a streamlined and comprehensive continuum of care.

Educational messages were designed to create demand for ANC services among pregnant women and their partners. Attention was given to messaging to encourage pregnant women to present for ANC care early (during the first quarter of their pregnancy) and to complete all four ANC visits, as recommended by the National Reproductive Health Program. In ProVIC-

supported health facilities, messages delivered by health care providers were aimed at encouraging women to accept HIV testing. Messages were also reviewed to cover family planning issues, gender-based violence, nutrition counseling, and malaria prevention.

After delivering these messages, PITC would then be offered to pregnant women presenting for ANC services, and to those coming to deliver who did not know their HIV status. Several approaches were used to increase male involvement, such as issuing letters of invitation to pregnant women to invite their male partners to the clinic to learn more about their family's health; offering testing to male partners accompanying their wives to the clinic for delivery; and adjusting service hours to better accommodate and encourage male partner participation in ANC services (e.g., on holidays, after work hours, and on weekends).

Routine ANC care --including TB screening and referral, syphilis testing and treatment, and SGBV screening--was provided to all pregnant women seeking services at ProVIC-supported sites. HIV-positive pregnant women were evaluated for their CD4 count, and clinically eligible women were placed on ART for life according to the national PMTCT protocol. Women with CD4 counts higher than 350 were placed on ARV prophylaxis for the duration of their pregnancy. At peripheral or "spoke" PMTCT sites, CD4 samples were transferred to central sites for analysis; this helped reduce loss to follow-up, by sending samples out for testing rather than asking the woman herself to travel to another site for CD4 testing. Cotrimoxazole was also administered to HIV-positive pregnant women during the second quarter of their pregnancy, and HIV-positive women were invited to join support groups. Providers worked closely with Mentor Mothers or facility-based social workers to improve adherence and retention of HIV-positive pregnant women throughout the PMTCT period.

Male partners, as well as other family members with positive test results, also received CD4 testing and care (e.g., cotrimoxazole, TB, and opportunistic infection-related services); those who were eligible were initiated on ART.

In addition to the minimum package of services provided at all spoke sites, the PMTCT team also introduced complementary services at hubs during this reporting period. This included blood transfusion safety, biological follow-up of patients on ART, and management of side-effects related to ARVs and cotrimoxazole.

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

This period, ProVIC continued to focus on increasing the promotion and uptake of pediatric counseling and testing and improving follow-up of mother-infant pairs. ProVIC also worked to ensure effective referrals of infected infants to treatment, and the initiation of HIV-exposed infants on CTX. The referral system for placing HIV-infected children on ART was strengthened through continued phone calls to mothers, and by strengthening the management site where referred women were followed up to better ensure the success of the referral.

Activities included efforts to reinforce the system for the follow-up of mother-infant pairs throughout the PMTCT cascade. To support these efforts, job aids developed by the ProVIC PMTCT team were further refined and continue to be used by providers at project-supported

PMTCT sites. In addition, strategies for reducing loss to follow-up, such as telephone calls from providers to clients and home visits to track clients not reachable by phone, were both used and encouraged. ProVIC continued to give health care providers phone credit for these client communications and transportation allowances to conduct these home visits.

Another form of follow-up care has included encouraging HIV-positive pregnant women to return to the health facility for delivery, where during the traditional, three day post-partum stay in the maternity, they received routine postnatal care that included family planning-based counseling. Exposed infants were initiated on ARV prophylaxis (nevirapine) just after birth for the duration of the breastfeeding period, and HIV-positive women received counseling on infant feeding practices, managing their infants' immunization calendar, monitoring infant growth, and the importance of early infant HIV diagnosis and cotrimoxazole initiation at six weeks of life.

Activity 3: Pilot and evaluate the Mentor Mother and other innovative approaches to improve the retention and adherence of mother-infant pairs in PMTCT services.

Performance-based financing (PBF) at Kikimi Hospital Center: In collaboration with both the DRC government (the Ministry of Health's Secretary General) and USAID, ProVIC launched its first PBF PMTCT pilot at Kikimi Hospital Center in Kinshasa. The Ministry of Health's PBF *Cellule Technique*, or technical team, has played an important role of building the capacity of CH Kikimi's health providers. After securing both endorsement from the DRC government and formal approval from USAID, ProVIC signed this PBF pilot FOG with CH Kikimi at the end of the second quarter.



Signing of the PBF contract (r-l): Trad Hatton (ProVIC), Dr. Pascal (CH Kikimi), Dr. Arthur (Bureau Diocésan des Oeuvres), Mr. Bukanga (PBF unit), and Mme Fanny (health zone team representative).

The Mentor Mother Approach: To improve the adherence and retention of HIV-positive pregnant women in PMTCT services, the PMTCT team targeted six PMTCT sites in Kinshasa, Katanga, and Orientale to pilot the Mentor Mother approach. The pilot's design was informed by EGPAF's experiences implementing the approach in Kenya.

In collaboration with PNLs and PNSR, and with support from EGPAF /DRC, ProVIC has developed National Guidelines for piloting the Mentor Mother Approach in the DRC. As part of this effort, 17 training modules and eight data collection tools have also been adapted. During the reporting period, 12 Mentor Mothers and 12 health care providers involved in PMTCT activities were trained on the Mentor Mother Approach. Mentor Mother activities were then launched in March 2013.



Monthly evaluation of Mentor Mother activities at CH Kingasani: At right, a Mentor Mother accompanied by her seronegative husband, who came to the facility to encourage his wife.

Activity 4: Increase the quality of PMTCT services.

Roll out URC's approach on quality assurance and improvement at 14 ProVIC-supported maternities: With support from URC, ProVIC selected 14 maternities (six in Kinshasa, six in Katanga, and two in Orientale) as QA/QI activity pilot sites. QA/QI activities began in four maternities in Kinshasa in January 2013, and following an orientation session for government partners, 28 coaches were trained to ensure ongoing coaching visits to targeted maternities. Three months into implementation, ProVIC facilitated a learning session with all of these actors as an opportunity to exchange ideas and improve service quality and site performance.



Changes implemented in maternities under the QA/QI teams. On the left, counseling box before: two providers working in the same area. On the right, counseling box after: providers are separated by a windbreak to ensure confidentiality.

CENTRE DE SANTE ET MATERNITE
LIBONDI
Av. Tatamena n° 115
C/BUMBU

LISTE DES ENFANTS EXPOSES

N°	Nom de la mère	Adresse	Date de naissance	6è semaine	9è mois	12è Mois	18è
01	KASONGO ZIZI	Kisantu 13/Sel	15/5/012	30/6/012	18/2/013	15/5/013	15/1
02	DIAKIESE SOLA		13/10/012	28/11/012	13/7/013	13/10/013	13/4
03	KIMFUTA		23/5/012	08/7/012	23/2/013	23/5/013	23/1
04	LANDU KIAMENGA		23/6/012	8/08/012	23/3/013	23/6/013	23/1
05	YALA SYLVIE		6/7/012	21/8/012	06/4/013	06/7/043	06/1
06	BUNGUDI MARIA		8/9/012	23/10/012	08/6/013	8/09/013	8/0
07	NSONA		19/5/012	04/7/012	18/2/013	19/5/013	19/1
08	FATU MATATA		19/12/012	2/02/013	19/9/013	19/12/013	19/1
09	NKUSU GEBE		20/1/013	07/3/013	20/10/013	20/1/014	20/1
10	WUMBA EWAYI		21/1/013	08/3/013	21/10/013	21/01/014	21/1



Register for exposed children displayed on the wall to improve follow-up.

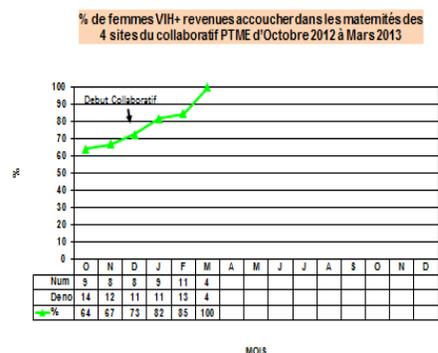
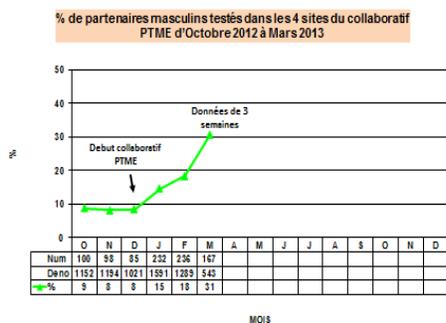
Improvements made to a delivery room.



USAID visit.



Presentation of a certificate to the best QA/QI team.



Appreciable evolution of some indicators from January to March 2013.

Activity 5: Increase linkages with maternal and child health services and other program areas.

ProVIC continues to engage at numerous levels to strengthen the continuum of care for HIV-positive pregnant women and their families—including by strengthening linkages to care and support, and by improving referrals. HIV-positive women and their families were referred to support groups led by Mentor Mothers, to facility-based social workers for psychosocial support, and/or for required medical attention, according to the needs of each client.

ProVIC leveraged the strategic pivot working sessions to organize, manage, and coordinate activities throughout the continuum of HIV care, including by developing a tool that includes all indicators for ProVIC’s integrated activities in the continuum of care. ProVIC will then use this tool for improved follow-up of activities during supervision visits, and to better ensure service quality standards at project-supported sites.

Table 2. Number of existing PMTCT sites providing continuum of care services.

Province	PMTCT	Adult ART	PITC	Care and support	Pediatric treatment
Bas-Congo	5	5	5	4	0
Katanga	14	14	14	10	0
Kinshasa	6	6	6	6	0
Province Orientale	6	6	6	6	0
Total	31	31	31	26	0

Activity 6: Strengthen the capacity of government at the national level to provide PMTCT services.

During the first quarter, ProVIC actively participated in meetings organized by the Ministry of Health’s national programs, including Technical Working Group (TWG) and MNCH Task Force meetings, offering suggestions and constructive feedback to challenges raised in the groups. ProVIC has also helped validate national MNCH standards, guidelines, and newly-integrated tools, and supported production and distribution costs for these tools to ensure their wide availability and use at the facility level. ProVIC also collaborated with the Ministry of Health at the national level to update the national child health card, with particular attention to enhancing pediatric care elements to improve follow-up of mother-child pairs.

Activity 7: Plan for the USAID Strategic Pivot.

During the last month of this reporting period, ProVIC adopted PEPFAR’s strategic pivot recommendations and committed to increasing PMTCT coverage within current health zones by

taking into account sites reflecting higher HIV prevalence and higher attendance by pregnant women. Based on these criteria, ProVIC has proposed the addition of 22 new PMTCT satellite sites within currently-supported health zones. Based on USAID’s new priority provinces in the DRC, the provinces selected for this expansion were Katanga (with 15 new sites), Orientale (with two new sites), and Kinshasa (with five new PMTCT sites currently planned). The peer-to-peer approach is also now starting to be used to support these new sites: satellite PMTCT sites are coached by sites with more experience and more experienced providers who have already been trained to deliver a complete package of PMTCT services.

In the meantime, ProVIC continued PMTCT activities in Bas-Congo and Sud Kivu provinces during the reporting period, without planning for the addition of new PMTCT sites. Preparations have begun to close down services in Sud Kivu, based on USAID’s decision to shift resources to other regions. For HIV-positive pregnant women tested in Sud Kivu, ProVIC is developing a transition plan to refer them to Global Fund-supported sites by the end of September 2013.

In certain health zones with markedly low attendance, ProVIC worked with health zone management teams to introduce an “advanced coaching strategy.” This strategy involves a principal site working with secondary, lower-volume sites to better reach pregnant women and ensure that those women have access to the continuum of care according to national standards.

In response to the strategic pivot, ProVIC conducted PMTCT site and needs assessments to strategically select those sites that would increase the use of PMTCT services by the greatest number of pregnant women. Seven new project intervention health zones were proposed through this process: four in Katanga (Kamina, Bukama, Dilala and Manika) and three in Orientale (Mangobo, Buta and Bunia). Pending USAID approval, ProVIC plans to introduce services at new PMTCT sites in these new health zones in the third quarter.

The addition of these new Health Zones will bring the total number of ProVIC-supported health zones to 28 (after also eliminating some current health zones that will be discontinued), with 44 new PMTCT sites identified for the gradual introduction of a complete package of PMTCT services (for a new overall total of 75 PMTCT sites)

Table 3. Distribution of PMTCT sites in existing and new health zones.

Province	Current health zones		New health zones	Total sites proposed
	Existing sites	New sites	New sites	
Bas-Congo	6	0	0	6
Katanga	14	15	11	40
Kinshasa	5	5	0	10
Province Orientale	6	2	11	19
Total	31	22	22	75

Table 4. PMTCT Cascade indicators by province

PMTCT CASCADE INDICATORS	Bas Congo	Katanga	Kinshasa	Province Orientale	Sud Kivu	Total Year 4 Q1+Q2 achievement	Percent achievement against internal target (%)
Number of pregnant women received at ANC	2,288	5,934	8,855	1,388	2,448	20,913	
Number of pregnant women counseled during ANC service	2,288	5,934	8,855	1,388	2,448	20,913	100
Number of pregnant women counseled during L&D service	861	1,621	1,072	157	1,887	5,598	21
Total number of pregnant women counseled (ANC and L&D)	3,149	7,555	9,927	1,545	4,335	26,511	
Number of pregnant women tested for HIV	3,146	5,543	9,927	1,545	4,335	24,496	92
Total number of pregnant women tested for HIV (ANC and L&D) and who received their tests results	3,146	5,543	9,927	1,545	4,335	24,496	100
Total number of HIV-positive pregnant women tested for HIV (new positives identified, ANC and L&D)	55	199	108	38	44	444	N/A
HIV seropositivity (pregnant women)	1.7	3.6	1.1	2.5	1.0	1.8	
Number of known HIV-positive women at entry	7	31	30	7	14	89	N/A
Total number of HIV-positive pregnant women	62	230	138	45	58	533	
Number of HIV-positive pregnant women who received CD4 count testing (during ANC and L&D services)	60	198	134	38	28	458	86
Number of HIV-positive pregnant women with CD4 counts < 350 (ANC and L&D)	23	79	80	12	17	211	44
Number of HIV-positive pregnant women placed on maternal AZT	35	95	93	30	41	294	61
Number of HIV-positive pregnant women who received ART	20	88	43	12	15	178	37
Number of HIV-positive pregnant women referred to self-support groups	30	32	64	29	23	178	38
Number of HIV-positive pregnant women retained in self-support groups	23	32	57	12	23	147	83
Total number of HIV-positive pregnant women who received ARVs to reduce the risk of MTCT	55	183	136	42	56	472	89
Total number of HIV-positive pregnant women who delivered at the maternity	38	111	71	20	16	256	48

PMTCT CASCADE INDICATORS	Bas Congo	Katanga	Kinshasa	Province Orientale	Sud Kivu	Total Year 4 Q1+Q2 achievement	Percent achievement against internal target (%)
Number of HIV-exposed infants receiving ARVs for PMTCT	40	109	70	21	18	258	101
Number of infants born to HIV-positive pregnant women who received an HIV test within 12 months of birth	27	64	117	21	40	269	50
Number of HIV-exposed infants tested for HIV at 18 months	0	4	4	4	4	4	
Number of HIV-exposed infants tested for HIV at 18 months identified as HIV positive	0	0	0	0	0	0	
Number of infants born to HIV-positive pregnant women who were started on CTX prophylaxis within 2 months of birth	14	64	76	19	22	195	37
Number of male partners of pregnant women tested for HIV	137	207	1,163	290	178	1,975	8
Number of male partners of pregnant women who tested HIV-positive	5	24	18	6	4	57	
HIV seropositivity (male partners)	3.6	11.6	1.5	2.1	2.2	2.9	
Number of male partners of HIV-positive pregnant women who received CD4 count testing	3	5	12	0	3	23	40
Number of male partners of HIV-positive pregnant women with CD4 counts < 350	0	3	6	0	1	10	43
Number of male partners of HIV-positive pregnant women who received cotrimoxazole prophylaxis	3	3	24	0	4	34	60
Number of male partners of HIV-positive pregnant women who received ART	0	3	5	0	1	9	90
Number of other family members tested for HIV	1	20	13	7	0	41	8
Number of other family members who tested HIV positive	1	1	0	0	0	2	5

Legend: Yellow: good performance; Green: low performance due to activity start-up during Q2; Pink: seropositivity; Light blue: weak performance.

The following trends can be observed from this data:

1. Over the course of this semester, 20,913 women received HIV counseling at the ANC and 5,598 at labor and delivery. Thus 21 percent of ProVIC clients presented first at labor and delivery. Of the total 26,511 pregnant women counseled, 24,496 women, or 92.4 percent, were tested for HIV and received their results.
2. During the period, 533 pregnant women who received PMTCT services were HIV positive; of these women, 444 were newly tested and identified as HIV-positive by ProVIC, and 89 women presented with a known HIV-positive status. These results reflect a seropositivity of 1.8 percent among pregnant women who accepted HIV testing at ProVIC sites. This overall seropositivity figure masks certain trends, however, such as the higher prevalence of ProVIC PMTCT clients in Katanga (at 3.6 percent) and in Kisangani (at 2.5 percent). ProVIC is focusing special attention on these sites to ensure quality services, retention, and follow-up for pregnant women and their exposed infants.
3. Of the 533 HIV-positive pregnant women mentioned above, 458 were clinically evaluated through CD4 testing and 211 were evaluated using WHO staging. 472 HIV-positive women (or 89 percent) were placed on either ARVs for PMTCT or ART for life (with 294 women, or 55 percent, placed on maternal AZT and 178 women, or 33 percent, placed on ART for life).
4. During the course of this semester, 256 HIV-positive pregnant women delivered at ProVIC-supported PMTCT sites, and 258 infants (or 101 percent, due to some twin births) of infants born to HIV-positive mothers received ARV prophylaxis to prevent HIV transmission during the recommended breastfeeding period.
5. Early infant diagnosis of 269 HIV-exposed infants was also conducted during the six-month reporting period, and 195 infants were initiated on cotrimoxazole prophylaxis. All four HIV-exposed infants tested for HIV with a rapid test at 18 months of age were found to be HIV negative.
6. 1,975 male partners of supported pregnant women (or 8 percent of partners) were counseled and tested for HIV and received their results during this period. Of these men, 57 were HIV positive, reflecting a seropositive rate of 2.9 percent rate among male partners of ANC clients who had accepted an invitation to visit the ANC site. Ten out of 23 men who received CD4 count testing were treatment eligible, and nine of these ten treatment-eligible men were placed on ART. Thirty-four male partners were placed on cotrimoxazole prophylaxis.
7. 41 other family members were tested for HIV, of whom two tested HIV positive; one person was placed on cotrimoxazole.

Comments and/or analysis of the results: These results are encouraging, as 43 sites (including 25 new PMTCT Acceleration sites) are now offering PMTCT services. Implementation challenges around launching new PMTCT sites during the first quarter of this year must also be accounted for when comparing these results against targets. These challenges included low health provider capacity in using rapid HIV tests, drawing samples for CD4 counts, and conducting EID, and their discomfort in disclosing positive HIV test results to clients. ProVIC worked attentively with partners over the second quarter to improve the quality of these services, and to coach providers through the disclosure process. The project team continues to work with sites and health zone staff to address these issues.

In spite of these challenges, and slow start-up of activities in some PMTCT Acceleration sites, the number of pregnant women who were counseled and tested for HIV, and who received their

results (24,496 women) represents an impressive 98 percent achievement against the project's semi-annual target. The proportion of HIV-positive pregnant women on ARVs (89 percent) is also encouraging, reflecting ProVIC's intensive coaching of providers and the implementation of quality improvement teams at Kinshasa's maternities that had previously suffered higher rates of clients lost to follow up.

As noted above, ProVIC's continued retention improvement efforts include pilot activities such as the Mentor Mothers Approach. Project data also suggests that children born to HIV-positive women who delivered in health facilities are being correctly cared for, and that rate of EID was improved during this reporting period (at 50 percent, higher than the project's targeted 40 percent). Initiation of infants on CTX at six weeks of age is working well, as is syphilis testing at sites in three provinces where these activities began during the first quarter.

Collaboration with and linkages between PMTCT sites and self-help groups, while weak in earlier periods, has greatly improved—including due to the introduction of Mentor Mothers. It is worth noting that 178 HIV-positive pregnant women have been referred to self-help groups during the reporting period; of these women, 147, or 83 percent, have been retained in their support groups.

Male involvement in PMTCT has also improved through the mechanisms implemented by quality improvement teams mainly in Kinshasa: QA/QI activities resulted in increased male involvement over the first half of Year 4, from five percent in the previous period to eight percent by the end of the reporting period. HIV-positive male partners now receive CD4 testing and are initiated on ART if clinically eligible. Efforts are also being made to increase HIV testing among other family members of HIV-positive pregnant women; for the first time, this rate has increased, and now includes care and support to those identified as HIV positive.

The collaboration and linkages between PMTCT sites and the self-help groups was weak at the beginning of the program. With concerted effort, this has been greatly improved and Mentor Mothers have been important in this overall improvement. A total of 155 HIV-positive pregnant women were referred to a self-help group and 124 (80%) have been retained in their group.

Male involvement also improved, through the mechanisms implemented by the quality improvement teams, mainly in Kinshasa, as shown by results for QA/QI activities for male involvement, which were 5% for the previous period and are 8% now. HIV-positive male partners are now tested for CD4 levels and initiated on ART if clinically eligible. Efforts are also being made to increase the testing rate of other family members of HIV-positive pregnant women, which for the first time increased to 8%, including care and support provided to family who tested HIV positive.

Analysis of continuum of care in PMTCT sites during Q1 & Q2

Table 5. Continuum of care for all PMTCT clients

Targets	Interventions					
	PITC	FP counseling	Syphilis screening	Syphilis treatment	TB screening	SGBV Screening
Pregnant women	24,496	5,583	9,510	58	10,818	698
Male partners	1,975			40		
Other family members	41					

This table shows that during ANC services 9,510 pregnant women were tested for syphilis, and 58 positive cases were identified and treated along with their male partners according to the PNLs methodology. 10,818 pregnant women (both positive and negative for HIV) were screened for TB, with just one case of TB/HIV co-infection found. 698 pregnant women (both positive and negative for HIV) were screened for SGBV (132 victims of SGBV were identified), and 5,583 were counseled on family planning methods.

Table 6. Continuum of care for HIV-positive individuals

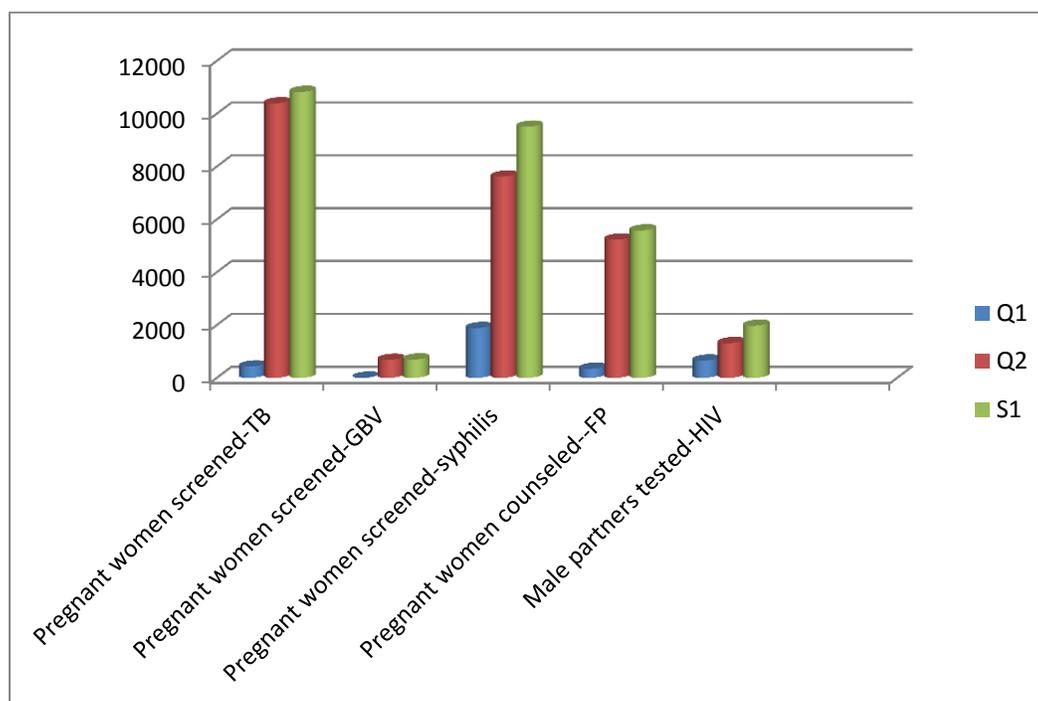
Targets	Interventions									
	CD4	CTX	AZT	ART	NVP	EID	Ped. treat.	FP	PS support	NACS
HIV-positive pregnant women	458	436	294	178				49	147	73
HIV-positive male partners	23	34		9						
HIV-exposed children		195			258	269	2			
Other HIV-positive family members	1	1		0			0			

This second table illustrates how individuals tested for HIV identified as HIV-positive (e.g., pregnant women, male partners, HIV-exposed infants, and other family members) are increasingly benefiting from ProVIC's package of continuum of care services and support.

The overall number of beneficiaries, while still low, is nonetheless encouraging, as ProVIC initiated efforts to develop linkages between PMTCT services and care, treatment, and support services only during the second quarter of this project year.

The graph below shows the evolution of some indicators, which, while weak at the beginning of the year, have improved over the course of the semester.

Table 7. Evolution of improvement in selected indicators from Q1 to Q2, Year 4



Challenges during the reporting period and proposed solutions

Challenges	Proposed solutions
Integration of the care and support package in new sites for continuum of care.	<ul style="list-style-type: none"> • Build the capacity of providers during site visits. • Supply commodities for continuum of care services. • Develop efficient referral and counter-referral systems between health facilities and support groups.
Coordination of activities within the PMTCT component.	<ul style="list-style-type: none"> • Develop an integrated tool for follow-up of the continuum of care package by PMTCT teams. • Enhance linkages and working meetings between the PMTCT component and the care, treatment, and support component.
ProVIC was forced to slow down PMTCT activities, particularly the training for new sites, due to delays in the USG signing its cooperative framework with the DRC government, which in turn delayed ProVIC's obligation of additional funding. By delaying planned PMTCT integrated training, ProVIC mitigated this risk until the Cooperative framework was signed and ProVIC's obligation was completed	<ul style="list-style-type: none"> • As the framework is now signed, this problem should arise again and ProVIC expects to receive new obligations as planned.

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

Activities and achievements

During the first half of 2013, ProVIC continued to integrate GBV activities in 14 health facilities offering PMTCT services, and continued to implement advocacy activities at the community level through the 14 existing champion communities in the two target provinces of Kinshasa and Orientale. All 14 PMTCT sites have completed GBV screening/testing (including six in Kisangani and eight in Kinshasa), and among them, eight hub locations throughout eight intervention sites have been supported to provide medical care and services to victims of GBV (including three sites in Kisangani and five in Kinshasa). In six other satellite sites/spokes that do not offer direct care for GBV survivors, individuals identified as SGBV survivors were referred to hub sites for appropriate care.

Sites that conduct GBV screening are in Kisangani (Mokili, Malkia wa Mashaidi, Neema, Pumuzika, St Camille Muungano) and Kinshasa (CH Kikimi, *Centre de Santé* [CS] Kikimi Kingasani, Binza Meteo, Libondi, Mbankana, *Hôpital Général de Référence* [HGR] Bisengo Mwambe, and Londolobe). In Kisangani, we also tested the GBV screening (tool and process) at the Pumuzika integrated HCT site.



Focus group on SGBV and HIV/AIDS with the Young Islamic Association of Kabondo.

Activity 1: Develop the “Champion Men/Champion Women” approach in communities to strengthen the participation of men in activities against SGBV.

From December 3 through 9, 2012, 80 ReCos and peer educators (including 38 women and 42 men) from four champion communities in Kisangani (Kabondo, Malkia, Neema, and Pumuzika) benefited from capacity-building through an integrated seven-day training around HIV/AIDS, gender-based violence, and family planning. ProVIC led this training, in collaboration with the PNLs, PNSR, and full DIVGFE team. Participants included local leaders, students, and young people, teachers, police, CSWs, and MSM. The training supported beneficiaries to acquire skills in planning social mobilization activities in schools, churches, local associations, and homes, among other locations, to promote gender equality and voluntary HIV testing, to discourage gender inequitable social norms, to inform community members about contraceptive methods,

and to provide information on sexual violence as it relates to the law. ProVIC used training materials adopted by the DRC government, and welcomed the significant involvement of government partners (DIVGFE, PNLs, BCZS [*Bureau Central de Zone de Santé*], and PNSR). The training emphasized the integration of HIV/AIDS, gender-based violence, and family planning activities, and the need to work closely with BCZS, health facilities supported by ProVIC, self-help groups, and other actors in the fight against gender-based violence and HIV.

ProVIC and partners commemorated International Day for the Elimination of Violence against Women (November 25, 2012) and the 16 days of Activism Against Gender Violence (November 25–December 10, 2012), through a variety of activities, such as:



Youth outreach with the Club Excellence Jeune in Kabondo/Kisangani.

- Advocacy efforts supported by the mayor of Tshopo targeting community policymakers to launch the International Day for the Elimination of Violence Against Women in Pumuzika Champion Community, attended by 58 people.
- An awareness-raising session in the Malkia school in Malkia Champion Community on December 13, 2012, on the elimination of violence against women. A total of 47 people (31 teachers and 16 leaders of women’s associations) participated in this activity.

ProVIC has also specifically focused on youth in its efforts related to gender-based violence. On March 8, 2013, International

Women’s Day, Kabondo/Kisangani Champion Community, in collaboration with the Kabondo youth club, *Club Excellence Jeune*, held an information session for 65 young people on SGBV and HIV/AIDS among young people, and on March 17, the community organized a group discussion for 27 members of the Young Islamic Association to discuss SGBV and HIV.

Activity 2: Support health care providers to effectively screen for gender-based violence in the PMTCT setting.

ProVIC organized two training sessions for health care providers on the management of SGBV in Kinshasa (October 9-13, 2012) and Kisangani (November 22-26, 2012), for a total of 40 doctors and nurses. The PNSR, in collaboration with ProVIC and the Ministry of Gender, Family and Children, designated four facilitators supported by the MOH to collaborate in these trainings. A pre-training assessment around knowledge and beliefs about GBV was administered to providers to help facilitators tailor the trainings. Beyond the five sites selected for GBV activities, medical staff at the three new PMTCT spoke sites (Londolobe, Bisengo Mwambe, and Mbankana) also received the training, and have been supported by ProVIC to conduct screening and referral services for GBV survivors.

The DRC does not yet have a standardized SGBV screening tool. At this time, ProVIC is supporting health care workers in PMTCT sites and self-help groups to use a screening form developed by the University of North Carolina and the PNLs. Based on service provider feedback, ProVIC has adapted this tool slightly, including the addition of key questions to distinguish between physical, psychological, and sexual violence to help providers refer appropriately.



Session on GBV tools with providers from CH Kingasani.

The screening tool was made available in all PMTCT sites in Kinshasa and Kisangani, and is used by providers trained to conduct screening of GBV among pregnant women who have received counseling, their partners, and other target groups. Follow-up visits were conducted immediately after the training at sites in Kisangani (Mokili, Neema, and Malkia) to monitor implementation of activities, review and explain to facility staff the indicators and expected targets, and identify gaps in materials and equipment.

In Kinshasa, five follow-up visits were conducted at the sites. These visits included supporting facility staff to conduct screening, reporting, and registration of GBV cases; reminders about correct administration of post-exposure prophylaxis (PEP); and completion of monitoring data for GBV survivors.

ProVIC, in collaboration with five grantees, held five training sessions for facilitators from self-support groups and C2C groups on GBV and GBV screening in order to strengthen their capacities to screen for GBV among PLWHA and OVC, refer survivors to the appropriate services, and follow up cases as needed. The sessions reached 78 participants, including self-help and C2C group leaders, CPCC presidents, and grantee staff responsible for M&E.

Activity 3: Provide high-quality medical and psychosocial support services to SGBV survivors.

Despite Supply Chain Management System-related delays in the procurement of PEP kits, ProVIC was able to obtain 39 kits from the United Nations Population Fund (UNFPA) and supply them to eight sites, including five in Kinshasa and three in Kisangani. ProVIC also supplied sites with GBV case management and data collection tools, including medical records for survivors of sexual violence, a sexual violence registry, medical certificates, medical record reporting, and monthly reports. The necessary equipment and materials have been incorporated into the Fixed Obligation Grant (FOG) agreements.

Sexual violence referral forms have been distributed to the various ProVIC-supported GBV care sites, and ProVIC has developed and distributed referral and counter-referral logs. However, the referral system itself still needs to be improved.

Activity 4: Strengthen the capacity of national partners, intervention partners, and key stakeholders to lead efforts to address GBV, and improve the management of information-sharing on GBV.

ProVIC has either led or participated in a number of SGBV coordination efforts, including meetings with US and DRC government partners to plan joint advocacy and sensitization activities, and to address challenges in PEP kit procurement and national contingency plans for the medical care of SGBV survivors.

ProVIC GBV staff participated in a refresher training for health care providers in the Champion Community of Binza Meteo, at which five other PMTCT providers were also briefed on the medical management of SGBV survivors.

Onsite supervision has allowed ProVIC’s GBV specialist to identify technical gaps and discuss corrective measures with health care providers, including challenges in the following areas: (1) developing an annual action plan; (2) conducting and documenting combined sensitization activities, including GBV and HIV; (3) accurately reporting data from integrated HIV/GBV outreach activities on data cards; (4) fostering collaboration between health facilities and police; and (5) improving referral and monitoring mechanisms.

Table 8. Analysis of results.

GBV indicator	Achieved result	Expected result	Gap
Number of persons provided with PEP.	23	336	313
Number of people reached by an individual, small group, or community-level intervention or service that explicitly addresses GBV and coercion.	22,065	126,000	103,935
Number of GBV service encounters at health facilities.	3,334	10,400	7,066
Number of health facilities reporting that they offer (1) GBV screening, and/or (2) assessment and provision or referral to the relevant service components for the management of GBV-related health needs.	15	13	(+2)

Comments and/or analysis of results

Setting realistic GBV targets has been a challenge for ProVIC; until GBV was integrated into ProVIC in late 2012, there was no previous experience on which to base the estimates. This is particularly the case for those offered PEP services.

Per results presented in the table above, 22,065 people were reached with GBV messaging by individual awareness-raising and peer education, or in small groups. However, these figures are low compared to the expected number: an achievement of 17.5%. The most-reached age group was that of 25 and older (95%). Men represented 50.1% of all people sensitized, versus 49.9% for women. The slowdown of activities in preparation for the PMTCT Strategic Pivot in Q2 had a negative impact on the performance of the champion communities, especially in Kinshasa.

Of the 2,696 people who underwent GBV screening, 238 (8.8%) were male and 91.2% were female (of these 2,321 women, 86% were pregnant). All groups have been reached by GBV services in PMTCT structures, predominantly in the 25 years and older age category (68.3%), followed by 18- to 24-year-olds (24.7%). Children aged 0 to 4 years were also reached, although only a small proportion (0.2%).

The achievement rate for indicator P.12.6.D is currently around 32%. Low results in Kisangani were due to, among others reasons, under-reporting from structures that only reported the positive GBV screening results, which was a misunderstanding of the indicator and needed correction through supportive supervision.

A total of 15 structures have reported that they offer GBV screening/assessment, more than the 13 expected (an achievement of 115%). This is due to the fact that GBV services were added in a VCT site in Kisangani (CS Pumuzika), and a PSSP site completed the GBV screening with PLWHA and OVC in self-help and C2C groups it supervises.

Challenges during the reporting period and proposed solutions

Challenges	Proposed solutions
Completeness and timeliness of reporting at the facility level through the GBV datacards.	Provide ongoing support to sites in data completion and data quality.
Absence of a specific approach to address mental health issues related to GBV.	Coordinate with the National Mental Health Program and the PNSR on future trainings.
Delay in receipt of PEP kits ordered.	ProVIC received support from UNFPA to allow the supported medical structures in Kinshasa and Kisangani to meet immediate needs.

Key upcoming activities for Intermediate Result 1

Sub-IR 1.1 <i>Communities' ability to develop and implement prevention strategies strengthened</i>	Sub-IR 1.2 <i>Community- and facility-based HCT services enhanced</i>	Sub-IR 1.3 <i>PMTCT services improved</i>	Sub-IR 1.4 <i>Community- and facility-based GBV prevention and response services strengthened</i>
Organize sensitization with key HIV prevention messages for MARPs and youth.	Train health providers on PITC, laboratory testing, and biomedical waste management using the integration training approach, focusing on PMTCT.	Finalize new sites for PMTCT services in line with the Strategic Pivot.	Integrate GBV activities into PMTCT structures in Katanga.
Reproduce and disseminate different communication tools.	Supply HCT, PITC, and PMTCT facilities with necessary	Train/Update health providers on PMTCT processes (within the larger context of ART).	Develop a strategy to increase the involvement of men in PMTCT activities

Sub-IR 1.1 <i>Communities' ability to develop and implement prevention strategies strengthened</i>	Sub-IR 1.2 <i>Community- and facility-based HCT services enhanced</i>	Sub-IR 1.3 <i>PMTCT services improved</i>	Sub-IR 1.4 <i>Community- and facility-based GBV prevention and response services strengthened</i>
	commodities.		(Champion Men approach).
Train providers at youth-friendly centers on HIV prevention and syndrome management of STIs.	Support the implementation of quality assurance in PMTCT partner facilities.	Continue implementation of the URC QA/QI approach.	Monitor and supervise joint GBV activities.
Organize meetings among champion communities to exchange best practices.	Support PNLs validation of training materials and PITC data collection.	Provide quality assurance and other necessary technical assistance to partners.	Document success stories related to GBV.
Transform existing CPCCs into local community-based associations with legal status.	Support joint supervision of HCT and PITC and biomedical waste management activities.		

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

In line with WHO and USAID's strategy of building sustainable, community-level responses to HIV/AIDS, ProVIC works to strengthen the capacity of its grantees to offer high-quality care and support services and facilitate access to treatment, where available. These services focus on strengthening linkages between community structures, PLWHA self-help groups, C2C groups, and families, and on improving access to a wide range of HIV/AIDS-related health and social services. Over the reporting period, ProVIC was also in discussions with USAID regarding OVC programming and now there is a sharper focus for the project on key elements of OVC support to be provided.

Sub-IR 2.1: Palliative care strengthened

Activity 1: Early identification of HIV-infected persons, and linkages to and retention in care.

The key to strengthening services for PLWHA is early identification of HIV-infected persons and their subsequent linkages to and retention in care.

Site monitoring visits took place on a regular basis in Q2, and have enabled ProVIC to measure the degree of integration of self-help groups and other care, support, and treatment activities within the target health facilities. To date, 18 self-help groups have been integrated into health structures (PMTCT sites) in the different provinces where ProVIC works (six mixed and two PMTCT groups in Kisangani, six PMTCT groups in Bas-Congo, one mixed group in Katanga, and two PMTCT groups and one mixed group in Kinshasa). Quality assurance teams have been established in Kinshasa to ensure the quality of services provided by facilities at the community level. The expansion of these teams will continue into the other provinces in Q3.

A number of meetings have taken place between communities and government partners (PNMLS, PNLs, and others) in the provinces of Kinshasa, Kisangani, Bas-Congo, Sud Kivu, and Katanga, which have enabled discussion and action planning to address improvements to the system of referrals between communities and health facilities. For example, referral tools have been provided to all implementing partners and to PMTCT sites to allow better documentation of this activity within the specific sites and communities. ProVIC has developed "inventories of services," which have been made available to all partners in each Champion Community and health site in order to facilitate referrals. In addition, field monitoring missions have highlighted the weaknesses of the existing government system and ensured utilization of the tools by care providers and community agents to strengthen the systems and ensure effective use.

Activity 2: Reduce morbidity and mortality of PLWHA through facility- and community-based interventions.

PEPFAR guidelines and DRC national guidelines regarding cotrimoxazole provision to 100% of PLWHA have been shared with all implementing partners. Cotrimoxazole stocks have been relocated to health facilities, and specific care providers have been designated focal points for the management of supplies provided by ProVIC. To enable traceability of cotrimoxazole provision, the distribution sheet designed by ProVIC is managed by the focal point and signed by the

recipient at each visit. To better coordinate this activity, the health zone lead doctors have been informed of this initiative and some stocks have been deposited with the central offices of the health zones for their deployment at site level once site requirements have been communicated.

To improve performance with regard to TB screening, a concerted focus has been placed on efforts to adhere to PEPFAR guidelines, which require that 100% of PLWHA benefit from TB screening. The draft collaboration agreement with the National League for TB and *Club des Amis Damien* (CAD) has been finalized, but activities under the agreement have not yet been implemented. Initially, USAID recommended that PATH TB 2015 provide financial support to the League and CAD to enable ProVIC to accelerate the active seeking out of cases of TB among PLWHA and awareness-raising among the general population, but USAID then announced that the TB 2015 program would not receive funding beyond September 2013.

In Q2, TB screening guidelines were shared with all provincial offices and grantees and the screening form has been made available to them. TB screening takes place monthly in the community and in health facilities and is systematically carried out by care providers for all PLWHA. All suspected cases are referred to the CSDT for diagnosis and medical care as appropriate. Home visits are conducted with families of people diagnosed with TB to raise awareness among other family members of the disease. A plan has been drawn up to accelerate TB screening in sites supported by ProVIC. Site monitoring in Q2 has helped to improve the capacity of health providers to systematically use the TB forms.

A key focus in Q1 was the training of caregivers in detecting malnutrition and in provision of palliative care. In Q2, ProVIC provided nutritional support following the Nutrition Assessment, Counseling, and Support (NACS) approach, systematically referring suspected cases to UNTI/UNTA, where PLWHA and OVC can access ready-to-use therapeutic foods. However, with the new strategic focus, NACS will be implemented by the Food and Nutrition Technical Assistance III Project and ProVIC support in this area will be greatly reduced.

Activity 3: Improve the quality of life of PLWHA.

Income-generating activities are generally progressing well. Regular monitoring in each province enables ProVIC to work with communities to create the conditions for their sustainability. The introduction of the Voluntary Savings and Loan Association approach with USAID partner Livelihood and Food Security Technical Assistance has also taken place within this component.

Home-based care visits have continued in Q2 and have enabled the provision of psychosocial support to a range of clients. They have also enabled ProVIC to identify people who had been lost to follow-up and re-link them to other services, such as palliative care, nutritional assessment, monitoring of ARV and TB treatment adherence, adherence to cotrimoxazole, and food and environmental hygiene advice. As a result of the PEPFAR Strategic Pivot, home-based and palliative care will diminish as a priority moving forward, and as such, the level and breadth of activities will downscale.

During exchanges with USAID in Q1, it was agreed that needs for insecticide-treated bednets should be quantified. The numbers required were communicated to USAID for approval and supply of the nets. Upon later recommendation by USAID, ProVIC will no longer distribute the

nets to avoid duplication of work already done in this area through the Global Fund and other USAID partners.

Challenges during the reporting period and proposed solutions

Challenges	Proposed solutions
The referral system continues to show significant gaps in performance.	<ul style="list-style-type: none"> • Sign the memorandum of understanding with the health zones. • Finalize and share service inventories; make referral slips available; integrate and mentor self-help and C2C groups within health facilities. • Referral systems have been a focus for ProVIC technical support for a long time, but results are lagging, so we are trying a new strategy. ProVIC intends to add referral systems to the QA/QI contract with URC, which is intensive and built on small team work.
Failure to diagnose suspected TB cases because of lack of financial resources.	<ul style="list-style-type: none"> • With the ending of the TB 2015 program, ProVIC will need to seek alternatives to TB 2015’s anticipated financial support to local TB-focused nongovernmental organizations. • Integrate the checklist for TB screening into mobile, static, and community VCT.
Lack of briefing for care providers on the provision of a minimum package of positive prevention.	<ul style="list-style-type: none"> • Organize training supervisions at sites to strengthen the capacity of care providers to provide the minimum positive prevention package.
Lack of availability of water purification treatments.	<ul style="list-style-type: none"> • Restate the need for water purification to ASF/PSI.

Sub-IR 2.2: Care and support for OVC strengthened

Activities and achievements

Activity 1: Support families to assess the needs of their children and to access the necessary services and support to decrease their vulnerabilities.

Based on feedback from USAID, Q2 has been focused on reflection, to determine where the OVC strategy for access to medical care can respond to OVC needs within the constraints of the health system. It is recognized that to be effective, medical care for OVC needs to be integrated into the partnership agreements between ProVIC and the health facilities. Within this context, social workers will be responsible for referring OVC to health facilities to receive medical care, after which the health facilities will ensure counter-referral.

To further support families, three sessions were organized in Kisangani in Q2, bringing together parents and children under the theme of “dialogue between parents and children within families.” Each session included on average 30 parents and children, along with social workers, who used participatory approaches, questions, and responses to gather the perspectives of parents and children. Practical guidance was provided to help families to have constructive exchanges with their children.

Activity 2: Strengthen OVC's education and address barriers to education.

ProVIC's HIV and OVC specialist held meetings with the Ministry of Primary, Secondary and Vocational Education (represented by three provincial division heads and chaired by the chief of party), the Ministry of Social Affairs, and the Catholic schools coordinating body (represented by the managers of six subbodies). The meetings produced the following decisions:

- The Ministry of Primary, Secondary and Vocational Education is willing to facilitate the integration of OVC identified by the grantees into public schools, under the provision authorizing the heads of these schools to provide free education for 10% of children considered to have social needs.
- The Catholic schools coordinating body is willing to support ProVIC and partners to increase educational access for OVC on the basis of a partnership agreement between with ProVIC.

During Q2, the care and support team developed summary guidelines for implementation of OVC activities. This summary, which follows PEPFAR guidance on OVC, highlights the priorities in terms of OVC education and is a valuable resource for planning and designing interventions at the community and health center levels.

Activity 3: Increase the awareness of families and other persons involved in child protection and children's rights on how to reinforce child protection and children's rights.

The child protection policy document has been finalized and disseminated to partners.

The new version of the C2C manual was produced in Q1 to provide a guide to group facilitators regarding planning and facilitating C2C meetings. A training workshop was organized in Kinshasa on the use of the C2C manual, attended by 63 facilitators and social workers. The new manual includes aspects of education around family life, reproductive health, hygiene, and environmental sanitation.

In Q2, further training sessions were organized in Kisangani for 30 C2C group facilitators. After the trainings, the facilitators began to sensitize children and parents before introducing the approach in Kisangani. Seven C2C groups have now been set up, bringing together 180 OVC and following the themes outlined in the new C2C manual.

Activity 4: Strengthen OVC capacity to deal with health and environmental issues.

The new version of the C2C manual was printed in Q1, providing guidance to C2C group facilitators on programming and facilitation of C2C meetings. The manual incorporates aspects of education around family life, reproductive health, hygiene, and environmental sanitation and is used by the C2C groups as a key resource. In addition, counseling cards have been developed which further provide support for C2C participants.

Challenges during the reporting period and proposed solutions

Challenges	Proposed solutions
USAID is requiring that ProVIC work with US Centers for Disease Control and Prevention (CDC) and Department of Defense (DOD) partners on OVC support issues, which is an increased burden on ProVIC staff, given the low capacity of CDC and DOD partners on this issue.	Provide ongoing coordination and support to CDC and DOD partners. Request ongoing clarity from USAID on ProVIC's responsibility. The latest understanding is that this is to begin in ProVIC-supported health zones and that ProVIC is not currently responsible for health zones in which the project is not present.
Difficulty in assisting grantees to register OVC and PLWHA with <i>Mutuelles de santé</i> .	Organize a tripartite meeting between ProVIC, grantees, and <i>Mutuelles de santé</i> to facilitate the registration of OVC and PLWHA.
Qualitative improvement in partnerships with human rights organizations and grantees.	Organize a meeting with human rights organizations and grantees.

Sub-IR 2.3: HIV treatment improved in target areas

Under the Strategic Pivot, ProVIC is greatly expanding PMTCT and adult treatment and introducing pediatric treatment. Therefore, Sub-IR 2.3 is new, and will be integrated into the revised statement of work. This section looks forward to future activities.

Going forward, all ProVIC-supported health facilities will also be adult treatment sites, with hub sites offering a full range of support services while spoke sites offer complementary services.

Pediatric care and support is a new activity within ProVIC, and will start in the second half of Year 4 at five central sites, two in Katanga (HGR Kenya and *Centre de Santé de Référence* [CSR] Kasumbalessa), two in Kinshasa (CHM Kingasani and CH Kikimi), and one in Kisangani (CSR Mokili). Pediatric care and treatment will extend gradually to other central sites from now to next year.

These sites were selected because they are already offering services with Global Fund or Clinton Foundation support. Therefore, in Year 4, ART support offered by ProVIC will be “indirect,” as coined by USAID/DRC. Funding will provide laboratory testing and diagnosis, technical support, completion of assessments, and referrals to other services, particularly for ARVs and other drugs provided by other partners while ProVIC waits for commodities, drugs, and other materials to offer “direct” treatment support. The activities envisaged within this framework will begin in Q3.

Key upcoming activities for Intermediate Result 2

Sub-IR 2.1 <i>Palliative care strengthened</i>	Sub-IR 2.2 <i>Care and support for OVC strengthened</i>	Sub-IR 2.3 <i>HIV treatment improved in target areas</i>
Identify additional ways to improve TB screening results, now that TB 2015 is coming to an end.	Highlight vocational and professional training opportunities while awaiting the start of the new school year in September.	Conduct an inventory at PMTCT sites planning for integration of care and treatment activities and new responsibilities.

Sub-IR 2.1 <i>Palliative care strengthened</i>	Sub-IR 2.2 <i>Care and support for OVC strengthened</i>	Sub-IR 2.3 <i>HIV treatment improved in target areas</i>
<p>Monitor and participate in grantee activities in the champion communities that have been retained (e.g., self-help group meetings and home-based care); emphasize TB/HIV co-infection, water safety, hygiene and sanitation, prevention of diseases related to dirty hands, prevention of malaria, and cotrimoxazole prophylaxis.</p>	<p>Finalize the OVC enrollment form; provide supervision and mentoring for the process of reclassifying the previous cohort of OVC; and integrate DOD and CDC OVC into ProVIC.</p>	<p>Carry out an assessment of the project's PLWHA, including:</p> <ul style="list-style-type: none"> • CD4 counts. • Biological follow-up of PLWHA on ART. • Other clinical follow-up.
<p>Document success stories.</p>	<p>Document success stories.</p>	<p>Increase services and care provided to exposed infants and improve follow-up.</p>
<p>Co-facilitate integrated training in Kisangani.</p>	<p>Set up a dynamic system that links recruitment of OVC, diagnosis of malnutrition, and referral for health care.</p>	<p>Continue discussions with USAID on provision of high-quality treatment services to all eligible beneficiaries, including the notion of “indirect” treatment support to a selected number of PLWHA. Discuss how quality services can be provided in a sustainable manner.</p>
<p>Participate in the development of the positive living guide with the PNLs and support the validation workshop.</p>		

Intermediate Result 3: Strengthening of health systems supported

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

During the first semester of Year 4, the ProVIC health systems strengthening (HSS) team has supported government institutions and ProVIC's nongovernmental organization (NGO) partners. In addition to the referral network activity described below, work with government partners has focused particularly on supervision, coordination, and leadership in HIV-related activities, and training of health care providers on HIV-related topics, including commodity management, PMTCT, and PBF systems. Work with the NGOs has focused on strengthening financial systems and governance so their community-based role is accountable.

Activity 1: Strengthen the referral and counter-referral systems.

Having established a referral network in both Bas-Congo and Sud Kivu in the last quarter of Year 3, the priority for this period has been to implement the referral networks in Katanga, Kinshasa, and Kisangani.

In Katanga, Kinshasa, and Province Orientale, ProVIC staff coordinated meetings to harmonize and integrate activities in collaboration with government HIV programs (PNMLS, PNLS, and *Division des Affaires Sociales* [DIVAS]) and key stakeholders, including service providers working with ProVIC in the main cities and other government representatives from health zones where ProVIC operates. All were briefed on the HIV referral network, particularly on the use of tools, the reporting system, and the follow-up mechanism.

The development of Kisangani's HIV service directory was coordinated by the ProVIC HSS team, rather than using a consultant as was done for other provinces. ProVIC collected data on the referral network during February and March, which served as the baseline before use of the improved referral tools (HIV service directory, and referral and counter-referral forms), which were reproduced and distributed for use in each city where ProVIC is operational.

The formal health zone health information system generates limited data from the collecting system for the purpose of the referral system. ProVIC is committed to ensuring these indicators are recorded and reported at the facility and health zone levels.

To ensure the commitment of health zone staff to ensure the follow-up of the referral network, ProVIC's new *Accords de Collaboration* with health zones will include referral indicators. The follow-up mechanism is based on ProVIC's support of the monthly monitoring meetings at the health zone level, involving community actors and health service providers. In the next period, the follow-up mechanisms under the referral system will be addressed and strengthened through accurate indicators related to referral.

Activity 2: Support the government's supervisory role at all levels.

At the health zone level, ProVIC has allocated monthly financial contribution to support supervision within the health zones via *Accords de Collaboration*, as described previously.

Supportive supervision visits were conducted by the technical executive teams of the health zones. In Kinshasa, a total of 17 supervision visits were conducted to the health and community facilities within the health zone. In Kisangani, the HCT service at the Pumuzika health center was supervised, including the PMTCT services at the Ya Bisso, Mokili, and St Camille health centers in Kabondo health zone. ProVIC supported the organization of monthly monitoring meetings for health zones in Kinshasa, Sud Kivu, Katanga, and Kisangani. Joint supervision was also financed by the national AIDS programs (PNLS, PNMLS) to supervise a few health centers (Neema, Mokili, Ya Bisso, and Pumuzika). In Katanga, the project supported 21 monitoring meetings across seven health zones (Kampemba, Kenya, Sakania, Panda, Kikula, Lubumbashi, and Kipushi). In Sud Kivu, 22 monitoring meetings were organized in five health zones to discuss data for decision-making at the health zone level.

In Bas-Congo, a joint supervision visit was conducted by the PNMLS, PNLS, and ProVIC to provide technical support to service providers in five health zones (Boma, Nzanza, Sekebanza, Matadi, and Moanda) in the main hospitals (Mvuzi, Kianvu, Kinzau, Kalamu, Boma, and Vuluma). Other direct support to health zones aimed to develop the high HIV risk mapping in Lukula and Boma health zones. This HIV high risk mapping captured information on key populations which will be used to inform and focus future interventions toward these groups.

In Kinshasa, ProVIC provided financial resources to organize 66 monitoring visits in 11 meetings at the health zone level. These meetings aimed to review and validate data by sharing best practices and experiences among partners and service providers.

Activity 3: Support leadership-building activities within programs.

ProVIC has provided financial and/or technical support to government structures at the provincial level to PNMLS and other active partners (PNLS and DIVAS) with their quarterly technical meetings and at their annual planning workshop. In Kinshasa, one coordination meeting was organized by the PNMLS with partners to discuss the 2012 activities and achievements and the Year 4 plan. The ProVIC HSS team also supported the PNLS annual review meeting, and the project contributed to the organization of the provincial health division annual review meeting. Other meetings were organized on a quarterly basis in Matadi, Kisangani, Lubumbashi, and Bukavu.

Activity 4: Build the capacity of health care providers.

In Bas-Congo, training on an integrated HIV package of services was organized in collaboration with the PNLS for 40 health service providers drawn from 18 health centers in six health zones. In Kisangani, other specific trainings were organized depending on the identified need to roll out the program in the new site. The following trainings were delivered in collaboration with the PNLS: data cards for M&E; peer education, family planning, HIV, and GBV for community workers; HCT/PITC; the Champion Community approach; nutrition for caregivers; use of the PIMA™ Analyser; GBV; peer education methodologies for CSWs and MSM; and the finger-prick technique for laboratory staff. Additional trainings were organized in Katanga and Bas-Congo, on peer education methodologies for key populations and biomedical waste management.

Activity 5: Support commodity management in the health zones.

A total of 13 facilities in Bas-Congo received follow-up visits from ProVIC’s logistician and pharmaceutical supplies expert, who provided support on commodity management in the health zones. The visits aimed to reinforce the capacity of service providers in commodity management, and refresh their knowledge of warehouse management. ProVIC has recruited a logistics officer for Katanga, who will now provide this type of supportive supervision.

Activity 6: Support the PNMLS in development of standards and guidelines.

Under the Strategic Pivot, this activity is no longer a priority and will not continue.

Activity 7: Produce and distribute tools.

Tools were produced and distributed in health and community facilities to facilitate data collection for M&E, including ANC, referral and counter-referral forms, HIV service directories in each province, and training materials.

Activity 8: Conduct integrated supervision.

ProVIC has developed an integrated tool for supervision visits which can be used by any staff member during field visits to provide insight on any program activities.

Challenges during the reporting period and proposed solutions

Challenges	Proposed solutions
Ensuring that the quality of the referral and counter-referral systems is maintained.	<ul style="list-style-type: none"> • Work with the PMTCT team to integrate quality management of referrals in health zones. • Add a referral system as part of QA/QI of Improvement Collaboratives in future Statements of Work with URC.

Sub-IR 3.2: Capacity of NGO providers improved

As a function of the Strategic Pivot, this activity will be scaled back significantly going forward, but this section represents considerable work done in the first six months of FY13.

Activities and achievements

Activity 1: Strengthen the organizational capacity of partner NGOs.

Work in this period builds on the results of institutional evaluations and subsequent capacity needs assessments which took place in the preceding project year. To date, 12 NGO partners have received visits from the capacity-building specialist (six in Kinshasa, four in Katanga, and two in Bas-Congo).

Of ProVIC’s 14 partners, only the two NGOs in Sud Kivu have not been visited for NGO capacity-building work; due to the pending closure of the Sud Kivu office, this activity will not take place.

In each of these NGO visits:

- Weaknesses revealed by the evaluations were shared.
- Progress since February-March 2012 was systematically evaluated.
- Plans to improve organizational governance were put in place with close support.

During these visits, well-studied frameworks provided a basis for beginning to improve key documents for the institutional development of the NGOs. This included:

- Improving administrative, accounting, and financial procedural manuals.
- Developing three- to five-year strategic plans.
- Developing operational plans and consolidated budgets, along with resource mobilization plans.
- Developing communications plans.

The work started during the visits continued through the sharing of various drafts via the Internet. The documents are now ready for at least 50% of the NGO partners visited (PSSP, Society for Women and AIDS in Africa, *Réseau National des Organisations d'Assise Communautaire* [RNOAC], AMO CONGO, *Organisation Non Gouvernementale Laïque à Vocation Socio-économique du Congo*, and World Production) and are awaiting approval by their boards and/or Annual General Meetings.

Particular attention has been paid to governance issues, which presented a number of pitfalls. To improve the situation, a session on governance was planned and prepared in detail but had to be postponed for further revision. The visits enabled discussions on the use of QuickBooks for accounting and finances, which is provided by ProVIC. However, grantees have not been using QuickBooks, and there are no restrictions on use of another package for reporting.

The NGO capacity-building specialist supported the ProVIC finance team by developing a checklist for close monitoring. The specialist took part in the ProVIC training on PBF and quality assurance. He is part of the coaching team collaborating on quality improvement.

Challenges during the reporting period and proposed solutions

Challenges	Proposed solutions
Issues with collection of referral data by grantees from the provinces, particularly in relation to sharing with health zones.	<i>Accords de Collaboration</i> will now include referral indicators to facilitate the sharing of appropriate data.

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

Overview

The first half of Year 4 has brought a substantial increase in the volume of data collected by the project—including due to the addition of 25 new public and private local health facility partners, the engagement of nearly 40 health zone partners, and the addition of some new PEPFAR

indicators. The recent DRC Strategic Pivot has created even further significant demands on, and architectural changes to, ProVIC's M&E system.

While ProVIC's M&E team has helped champion the massive coordinated response to the dynamic, rapidly evolving demands, they have also continued throughout the reporting period to help strengthen M&E systems and capacities. From conducting routine data quality assurance (RDQA) and joint supervision visits to working with the national government to improve its national health information system, ProVIC's M&E team has worked closely with project and NGO staff, health providers, and government M&E leads to, for example, more regularly collect, analyze, deploy, and improve data to inform decision-making at both the project and health system levels—locally, regionally, and nationally.

Activities and achievements

Activity 1: Strengthen ProVIC's M&E system through ongoing coordination with other technical areas.

During the first half of Year 4, ProVIC's national and provincial M&E teams conducted numerous monthly site visits, which included:

- Working to ensure the availability and correct use of data collection tools and M&E datacards.
- Strengthening local partners' understanding of all indicators in the PMTCT service cascade.
- Convening follow-up discussions with local partners on progress against these indicators.
- Following up on recommendations that emerged during RDQA exercises completed in 2012.

In Sud Kivu, every local implementing partner received at least one visit per quarter over the course of the semi-annual period. Some of these visits were made jointly with ProVIC's regional technical specialists (for each project component)—namely, three joint supervision visits with the regional prevention specialist and one joint supervision visit with the regional care and support specialist.

In Kisangani, ProVIC's regional M&E specialist made six supportive supervision site visits, at two visits per month, to all seven PMTCT sites newly engaged by ProVIC within the past year: the Malkiawa Mushaidi, Mokili, Neema, Yabiso, Pumuzika, and Muungano health centers. In collaboration with the PNLs provincial coordination bureau in Kisangani, ProVIC's full complement of data collection tools (for PMTCT, HCT, GBV, sensitization, HSS, and care and support) were distributed to all project-supported health facilities in this region.

ProVIC's PMTCT and M&E teams provided national-level technical support to the PNLs to update these tools, which were then distributed to project-supported sites. During a workshop led by ProVIC's national pediatric care specialist, regional M&E specialist, and chief medical officers from the Ibanda health zone in Sud Kivu in November 2012, PMTCT health providers from project-supported sites also learned in detail how to complete the following six new PMTCT data collection tools:

- Partograms—to record key maternal and fetal data during labor.

- Integrated prenatal consultation registers (records).
- Integrated preschool consultation registers.
- Registers for HIV-positive women and their male partners.
- Tracking sheets for HIV-exposed infants.

To improve data around TB screening for improved follow-up diagnosis and placement of PLWHA with TB on TB treatment, and to strengthen the accuracy and completeness of TB data reporting within the context of care and support data, ProVIC's care and support and M&E teams championed efforts during the first quarter of Year 4 to develop, disseminate, and train local partners on four new data collection tools:

- A home visit tracking tool.
- A self-help group data collection tool.
- An OVC enrollment sheet.
- An active TB case study/tracking tool.

Activity 2: Provide M&E technical assistance to the PNMLS, PNLs, and Ministère des Affaires Sociales (MINAS) at the national and provincial levels.

ProVIC's Bas-Congo and Sud Kivu M&E specialists actively participated in reviewing and/or planning 2012 and 2013 activities organized by the PNLs, in collaboration with ProVIC, during this reporting period. The project's provincial M&E specialists presented ProVIC data for each intervention component, which helped strengthen the government's understanding of the local HIV epidemics. During these annual, provincial-level coordination meetings, the project's planned interventions were also importantly integrated into the 2013 operational action plans (*plans d'action operationels*) of the health zones in which ProVIC operates. As part of this effort to ensure the strong harmonization and coordination of ProVIC-supported activities and health services with those of the local government, references to HIV/AIDS services were incorporated into and standardized across each project intervention health zone.

ProVIC's provincial M&E specialists also actively participated in first-quarter project review and second-quarter planning workshops. During these workshops, the project team and local implementing partners—including ProVIC's grantees and representatives from relevant health zone bureaus—collaborated closely to evaluate project performance from the first quarter of Year 4 and refine planning efforts for the second quarter. In some areas, this included identifying service and/or performance gaps, and then developing targeted catch-up plans that helped shape second-quarter activities.

As another form of technical capacity-building support to provincial-level government health ministries, ProVIC's Kisangani M&E specialist participated in Provincial Task Force meetings convened by the PNMLS. During these meetings, he contributed to validation of the provincial PNMLS 2012 annual HIV/AIDS report. The project's national M&E specialist participated in National Task Force meetings to contribute DRC data to the Joint United Nations Programme on

HIV/AIDS Global AIDS Response Progress Reporting. Through her contributions on behalf of ProVIC, ProVIC's programmatic data on MSM and CSWs were included in reported DRC data.

Activity 3: Strengthen MINAS M&E systems through joint missions and technical assistance in developing a national OVC database.

In Kisangani, in collaboration with ProVIC's regional care and support specialist, DIVAS, and local NGO partner FFP, the project's provincial M&E specialist helped coordinate the development of an OVC identification tool and establishment of an OVC database for improved follow-up of OVC through the facility- and community-based continuum of care. More than 650 OVC were newly identified and recruited into ProVIC's care and support program in this region alone through the launch and use of these tools.

In Sud Kivu, the project's regional M&E specialist convened a workshop with the DIVAS OVC specialist to strategize ways to improve OVC data reporting among NGO grantees. In a follow-up effort to harmonize the project's data reporting tools with those of DIVAS, the project team shared DIVAS' OVC data reporting template with the project's three NGO grantees in this region: FFP, *Association Coopérative pour la Synergie Féminine (ACOSYF)*, and *Association de Lutte pour la Défense des Droits de la Femme et de l'Enfant (ALUDROFE)*. Since disseminating this template, ProVIC's regional M&E officer has followed up to ensure sharing of the project's end 2012 and early 2013 OVC data with DIVAS, reported using this template.

Please see Activity 1 above for information on joint monitoring missions.

Activity 4: Build the M&E capacity of implementing partners.

Throughout the reporting period, ProVIC's M&E team continued their focused commitment to monitoring and improving the quality of data reported both by our local implementing partners and by the project overall—whether through peer-to-peer capacity-building, routine monitoring visits, internal audits, or RDQA, for example.

A total of seven RDQA sessions were completed in this reporting period—four in Sud Kivu, two in Bas-Congo, and one in Kinshasa. In Sud Kivu, this included a combination of NGO and health facility grantees—ACOSYF, ALUDROFE, FFP, and the Malka wa Amani health center—and focused on five critical PMTCT and care and support PEPFAR indicators, in recognition of the project's now even greater emphasis on these service types due to the recent DRC Strategic Pivot. ProVIC's Kisangani M&E specialist was trained at the end of the reporting period to perform RDQAs, and RDQA activities in this region will be launched in Q3. In Katanga, RDQA activities were suspended due to the grave health of ProVIC's regional M&E specialist; with the hiring of his interim consultant replacement, RDQA activities in this region will resume next quarter.

Activity 5: Build the M&E capacity of partners using the peer-to-peer capacity development approach.

In Year 4, ProVIC has continued to expand its peer-to-peer local M&E capacity development model, first piloted (and lauded by USAID) in Year 3. Activities this period have included continued peer mentorship of the Kinshasa-based NGO grantee RNOAC by another Kinshasa-

based NGO grantee, PSSP, around collecting and reporting data from C2C group meetings. ProVIC's Kinshasa M&E team observed RNOAC's marked improvement in this area in the Champion Community of Mafuta Kizola, for example, thanks to PSSP's ongoing coaching support. Most notably, RNOAC has shown improvement in their correct use of data collection tools, and in their data management practices.

Activity 6: Improve the capacity of implementing partners to conduct quality improvement and provide high-quality services.

In December 2012, ProVIC, the PNLs, and the project's QA/QI international consultant from URC jointly convened a three-day training workshop on quality assurance in health service delivery. All of ProVIC's national technical specialists and various ProVIC M&E staff participated in the workshop, which also covered leadership in service quality and the Improvement Collaboratives approach to improving particularly PMTCT service quality. As an outcome of this workshop, PMTCT collaboratives were established in four project-supported maternities in Kinshasa. ProVIC's national M&E specialist and Kinshasa-based M&E assistant participated in the launch of these collaboratives, playing the role of external coaches.

In March 2013, the international consultant conducted an evaluation of this pilot phase, citing extremely promising early results. The consultant made several recommendations as a result of the evaluation—including the recommendation to scale up this approach in other project-supported sites (in Kinshasa and other operating regions), and to adapt and implement this approach in ProVIC's other technical areas (not restricted to PMTCT).

Please see Sub-IR 1.3 above for additional information.

Activity 7: Provide ongoing datacard technical support to implementing partners to improve M&E reporting.

Since September 2012, ProVIC's M&E team has been working in close collaboration with the project's different national technical specialists to both develop and roll out a new GBV M&E datacard, and to progressively incorporate feedback solicited across all operating provinces from implementing partners, provincial- and national-level government stakeholders, USAID, and other key project stakeholders over the past year. The full complement of now six M&E datacards constitutes the heart of ProVIC's M&E donor reporting and synchronizes with the project's online M&E database.

The recent DRC Strategic Pivot has created substantial additional donor reporting demands on ProVIC's M&E system, for example, related to the new activities and services around monitoring and follow-up of TB diagnosis and treatment among PLWHA; diagnosis, treatment, and/or referral of project beneficiaries for STIs other than HIV; and ARV treatment for adults and children (i.e., no longer limited to ARV treatment only for mothers and their infants, within the context of PMTCT). It has also reinforced the need to ensure the M&E team's mastery in manipulating, extracting, and analyzing data from this expanding system.

To address these critical needs and help ProVIC rapidly and effectively respond to new contractual and other reporting requirements, substantial additional revisions are currently being

made to the project's M&E datacards in collaboration with PATH's M&E database consultant. This consultant will travel to Kinshasa in May to co-lead an M&E database capacity-building workshop for the project's M&E team and national technical specialists, with the following objectives:

- Review and ensure a strong, common understanding of substantial M&E datacard updates, which incorporate new project reporting requirements resulting from the recent DRC Strategic Pivot.
- Strengthen the team's capacity to use system-generated data to improve storytelling and inform project-level decision-making.
- Prepare for the launch of new database system functionalities, such as a basic commodities tracking system.

ProVIC's M&E and technical staff will then immediately apply their learnings from this workshop to conduct integrated trainings with the project's local implementing partners. This massive, highly coordinated exercise will be leveraged for another USAID-funded, PATH-led project in the DRC, *Projet SIDA Fungurume* (ProSIFU); ProVIC's updated datacards and integrated training curricula will be leveraged and adapted by ProSIFU in Fungurume and Kasumbalesa.

In the meantime, to encourage continued improvement in data quality and reporting during this period of substantial M&E datacard revisions, ProVIC's M&E team organized trainings on the current versions of the project's datacards with representatives from all 25 new (in FY13) public and private health facility partners. A total of 51 health providers participated in these onsite trainings, including 25 in Kisangani, 22 in Lubumbashi, and four in Sud Kivu.

Activity 8: Improve reporting through RDQA.

Since the aforementioned RDQA (per Activity 4, above) was completed, ProVIC has observed incremental improvements in the quality of data for RDQA-targeted project indicators among local partners audited—with positive results, in turn, for project-level reporting. That said, continued data quality-related challenges in Sud Kivu identified through these RDQA exercises include the following:

- Records management of sometimes very sensitive project data, both chronologically and confidentially.
- Rigorous understanding of how to track the project's cohort of care and support beneficiaries.
- Correct use and completion of certain current data collection tools.
- Rigorous tracking of the project's cohort of HIV-positive pregnant women and their HIV-exposed infants within the context of comprehensive PMTCT service delivery.

ProVIC's M&E team continues to work collaboratively with our partnering health providers, local government, and project technical specialists to explore ways to address these challenges.

In Bas-Congo, local NGO partners PSSP, *Centre Maman Kinzambo* (CEMAKI), and *Jeunesse Active pour le Développement Intégré et lutte contre le SIDA* were audited this reporting period using ProVIC’s RDQA tools. Analysis of the resulting RDQA reports revealed strikingly positive developments in data quality (in comparison to a previous RDQA conducted some months prior), for both CEMAKI and PSSP in particular (whose Matadi office nonetheless closed at the end of March due to management capacity challenges).

In Kinshasa, ProVIC’s now largest NGO grantee (operating in three provinces), FFP, was audited at the end of the first quarter of Year 4 by the project’s national M&E specialist and M&E assistant. RDQA findings revealed some M&E-related challenges, such as misused and/or incomplete data collection forms from sensitization sessions, and the unsystematic numbering of these sessions—which, in turn, affected FFP’s proper completion of the “sensibilization” M&E datacards. That said, signaling these data collection and reporting errors during follow-up RDQA review meetings with FFP—and importantly, pointing out how to correct the errors—has sparked their concerted efforts to improve in these areas (as observed in FFP’s Q2 reporting).

Challenges during the reporting period and proposed solutions

Challenges	Proposed solutions
Adapting ProVIC’s M&E system in response to the USAID Strategic Pivot.	Ensure that Strategic Pivot updates are systematically and promptly communicated to ProVIC’s M&E team and local partners alike; ensure that M&E activities, including the availability of updated data collection tools and regular field visits with the M&E focal points of local partners, are prioritized during this transitional period.
Low capacity of certain local partners in M&E, despite ProVIC’s ongoing and varied efforts.	Reassess the M&E capacity of local partners, and convene refresher M&E trainings as needed; continue and strengthen supportive supervision visits.
Ensuring continued, strong M&E project support in Katanga while ProVIC’s regional M&E officer was on medical leave due to serious illness.	Rearrange ProVIC’s internal existing M&E staff to fill this gap, and promote ProVIC’s Sud Kivu regional M&E officer to deputy national M&E officer to provide M&E oversight of both Sud Kivu and Katanga project activities (while based in Katanga).

Key upcoming activities for Intermediate Result 3

Sub-IR 3.1 <i>Capacity of provincial government health systems supported</i>	Sub-IR 3.2 <i>Capacity of NGO providers improved</i>	Sub-IR 3.3 <i>Strategic information systems at community and facility levels strengthened</i>
Strengthen the referral follow-up mechanism through referral indicators which are added to health zone accords and FOGs/Accords with health facilities	Follow up of technical activities delivered by NGO partners retained in the program	Convene and participate in a ProVIC M&E database update workshop in Kinshasa in early May.
Support DRC government AIDS program in its supervisory role at provincial and health zone level		Finalize the full complement of updated M&E datacards and orient all partners on their use.
Organize the integrated HIV training oriented to PMTCT for service providers in ProVIC sites ; HIV management for health zones in Katanga and Province Orientale		Participate in provincial and national PNMLS Task Force meetings.
Support quarterly multisectorial meetings with PNMLS		Work collaboratively with M&E focal points from the government's health ministries/programs (e.g., PNLs, DIVAS, etc.) and health zone offices to improve health data reporting within the National M&E AIDS Response System.
Reproduce and disseminate different communication tools targeting MARPs and general population, PMTCT, HCT, GBV, Care and support and for M&E		Continue to both conduct and follow up on RDQA activities in all provinces, particularly in new project-supported sites, to promote both improved data quality and stronger M&E capacity among ProVIC's local partners.

SECTION II. CROSS-CUTTING ISSUES

Administration and finance

The ProVIC Katanga Office in Lubumbashi was moved to a larger space to accommodate the expanding staff associated with the rapid expansion of local partners and health facilities in Katanga.

The ProVIC Sud-Kivu Office in Bukavu was moved for security reasons to a high-security neighborhood. This was proven to be an important move when M23 rebels captured Goma and threatened to march to Bukavu. The ProVIC office's position next to the well-guarded European Union building contributed to ProVIC's ability to continue operations with minimal disruption.

Recruitment

Over the course of Q1-Q2, ProVIC project replaced departed staff and added some new positions where needed.

In Katanga, ProVIC hired a full-time pharmacist to support the growing number of health facilities supported by ProVIC. ProVIC also replaced its Officer Manager and added a 50% time Grants Assistant who is also supporting the ProSIFU GDA with 50% time.

In Bas Congo, ProVIC replaced the Regional Coordinator with Dr. Didier Kamerhe after the departure of Anselme Manyong who was recruited away by the USAID project ROADS. Also in Bas Congo, ProVIC replaced its Secretary, Office Manager and Prevention Officer as Chanty Mombo was selected as PMTCT officer and moved to Kisangani with EGPAF.

In Sud-Kivu, Dr. Alexandre Kabanga was promoted from Care and Support Specialist to be Regional Coordinator for Sud-Kivu to ensure continuity and understanding of systems as ProVIC closes down its Sud-Kivu presence.

In Kinshasa, the National-level HCT and Prevention Officer's duties were expanded to include laboratory support. Gilbert Kapila, Regional Coordinator for Kinshasa, was shifted to take that position part time while maintaining his role as Regional Coordinator for Kinshasa.

In Kisangani, Dr. Jimmy Anzolo was hired as Prevention Officer.

Procurement and logistics

ProVIC is now fully integrated into the SCMS procurement system whereby ProVIC works with SCMS on quantifying commodity needs and SCMS procures and delivers to Kinshasa. The availability of ProVIC's commodities have shown improvement, although a late distribution of Determine tests created a situation in March 2013 whereby significant numbers of HIV tests were set to expire collectively. ProVIC accelerated mobile HCT to ensure these valuable resources were used and did not expire. In accelerating this mobile HCT, ProVIC was sure to strengthen referrals and coordination by having HZ and/or health facility staff involved in the mobile activity.

ProVIC continues to expand the use of Centre Distribution Regional (CDR) where these local institutions have demonstrated the capacity to manage ProVIC's commodities. ProVIC is now doing this in Matadi with CAMEBO and Kinshasa with CAMESKIN. ProVIC continues to expand the responsibilities of these CDRs, but tracking closely that USAID/PEPFAR commodities are managed with minimal risk.

Finance

The Field Accounting and Compliance team (FACT) from Chemonics headquarters in Washington, DC, conducted a project financial review in the Bukavu, Kinshasa, and Katanga offices in February 2013.

ProVIC was notified by USAID regarding pending Financial Review for Q3 of FY13. ProVIC's activities were slowed by a delay in incremental funding modification due to delays in the signature of the Cooperative Framework between the US government and DRC government.

To ensure that ProVIC did not have to lay off staff, activities were slowed until the DRC government's signature was secured and the incremental funding was guaranteed. ProVIC and USAID maintained close communication on this issue during this difficult period.

Grants management

From just a handful of partners just a few years ago, ProVIC's grant portfolio has expanded to encompass nearly 100 local partners—from local NGOs to public and private health facilities, and now, health zones as well. This has included new agreements with more than 30 health zones (through collaborative accords) and 25 new public and private PMTCT facilities (through accords and FOGs, respectively) over the past several months alone.

At the time of this report's preparation, ProVIC has already begun realigning this vast partner portfolio in response to the launch of the PEPFAR strategic pivot in February 2013. In some cases, pivoting will mean gradually closing down certain activities, partners agreements, and even regional project offices earlier than the end of the project's overall implementation period. Overall, all NGO grantee budgets will be reduced to reflect the pivot-driven shift from community-based care and support to integrated, facility-based care and support. Champion Community activities (through these NGO grants) will also take on a more targeted role—operating around PMTCT sites, and focusing on community mobilization around PMTCT and treatment adherence, rather than on more generalized messaging to the general population. And existing collaborative accords with health zones may be revisited to eliminate those whose coordination does not center squarely around project-supported PMTCT health facilities.

ProVIC's grants portfolio is also being reshaped to respond to the *geographic* implications of the strategic pivot. In Sud Kivu—no longer a priority province for PEPFAR—for example, ProVIC will be closing its grant with NGO partner ALUDROFE by the end of the second quarter and agreements with all eight remaining partners (NGOs, PMTCT facilities, and health zones) by the end of Year 4. And in Bas-Congo, also no longer a PEPFAR priority province (as noted under sub-IR 1.1), ProVIC will scale down and/or shift activities to focus primarily on facility-based PITC. In this context, local NGO partner PSSP—which had until recently supported project activities in both Kinshasa and Bas-Congo—has already discontinued mobile VCT activities in

this region. ProVIC’s broader, future presence in Bas-Congo is still otherwise under analysis. In the meantime, in recognition of the strong partnerships the project has cultivated over the past four years, ProVIC has made every effort to proactively communicate these shifts to project partners, DRC government, and other stakeholders, in consultation with USAID.

In other cases, ProVIC’s grants portfolio continues to significantly *expand*—particularly to reach a greater number of HIV-positive pregnant women and their families with the complete package of PMTCT services. As ongoing consultation with USAID, PEPFAR, and others continues to bring the project’s expanded geographic reach into clearer focus, ProVIC is taking a phased approach to this expansion. The project has already been rapidly deploying assessment teams to identify potential new PMTCT sites, with plans to sign new agreements with 22 new PMTCT facility partners (14 new FOGs and eight new collaborative accords) in *existing* project-supported health zones in Kinshasa, Orientale, and Katanga. The potential addition of PMTCT sites in *new* health zones (in the Bunia region of Province Orientale, for example) is also under analysis. Lastly, following consultation with USAID, ProVIC plans to provide a grant to local NGO Caritas-Congo, to provide schools with subsidies to expand educational and vocational training support to OVC in Kinshasa, Orientale, and Katanga.

These simultaneous contractions and expansions, both a delicate and complex exercise, is being carefully coordinated and communicated to ensure that ProVIC positions its interventions for both the strongest health outcomes and the strongest alignment with the vision of PEPFAR’s strategic pivot.

Environmental monitoring and mitigation activities

Activity	Potential negative environmental consequences	Status report
HCT	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 must be then properly stored and disposed of.	<p>All HCT and PMTCT sites have received training on waste management and regularly receive supplies (waste receptacles, cleaning supplies), and either have incinerators or have project funds available to correctly dispose of environmentally hazardous waste.</p> <p>All normative documents have been shared, including national policy, job aids, and guidelines and reporting templates for environmental protection.</p> <p>60 health workers in new HCT, PICT, and PMTCT Acceleration sites have been trained on medical waste management.</p>
PMTCT	PMTCT includes HCT and therefore the risks mentioned above. In addition, the labor and delivery process includes the use of syringes, needles, and other sharps. It also necessitates a way to remove the blood and other bodily fluids and clean and decontaminate the delivery area to prevent contact with potentially hazardous fluids.	<p>ProVIC provided refresher training for providers in 35 existing PMTCT sites and identified training needs in six new sites in Kisangani.</p> <p>The project constructed 2 incinerators in Bas Congo (HGR Boma, CSR Vulumba) and 2 in Sud Kivu (Nyatende, HGR Bagira). It upgraded one incinerator in Katanga (HGR Kenya) to service 16 existing PMTCT sites and identified needs in 26 new sites. ProVIC will respond to these needs</p>

Activity	Potential negative environmental consequences	Status report
		<p>during the second semester of PY4.</p> <p>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).</p>
Palliative care	Palliative care for PLWHA includes, as discussed above, both the use of hazardous sharps and exposure to bodily fluids which may be infectious.	Community health workers have been trained and receive appropriate supplies for home visits.