

DRC INTEGRATED HIV/AIDS PROJECT

PROJET INTEGRE DE VIH/SIDA AU CONGO (PROVIC) YEAR 4 QUARTERLY REPORT, QUARTER 3

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ACRONYMS AND ABBREVIATIONS

AIDS	acquired immune deficiency syndrome
ANC	antenatal care
ART	antiretroviral therapy
ARV	antiretroviral medication
BCC	behavior change communication
C2C	child-to-child
C-Change	Communication for Change
CDC	United States Centers for Disease Control and Prevention
CH	<i>Centre Hospitalier</i>
CS	<i>Centre de Santé</i>
CSR	<i>Centre de Santé de Référence</i>
CSW	commercial sex worker
DOD	United States Department of Defense
DQA	data quality audit
DRC	Democratic Republic of Congo
ECZS	<i>Equipe Cadre de Zone de Santé</i>
FY	Fiscal Year
GBV	gender-based violence
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
HGR	<i>Hôpital Général de Référence</i>
HIV	human immunodeficiency virus
HTC	HIV testing and counseling
IR	Intermediate Result
M&E	monitoring and evaluation
MOH	Ministry of Health
MSM	men who have sex with men
NGO	nongovernmental organization
OVC	orphans and vulnerable children
PATH	Program for Appropriate Technology in Health
PBF	performance-based financing
PEPFAR	United States 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> (National HIV/AIDS Program)
PNMLS	<i>Programme National Multisectoriel de Lutte Contre le VIH/SIDA</i>
ProVIC	<i>Projet Intégré de VIH/SIDA au Congo</i> (Integrated HIV/AIDS Project)
PSSP	<i>Progrès Santé Sans Prix</i> (Progress and Health Without a Price)
SCMS	Supply Chain Management System
SGBV	sexual and gender-based violence
STI	sexually transmitted infection
TB	tuberculosis
URC	University Research Co., LLC
USAID	United States Agency for International Development

EXECUTIVE SUMMARY

In late Q2 of Fiscal Year (FY) 2013, the United States Agency for International Development (USAID) formally announced the “Strategic Pivot” in the Democratic Republic of Congo (DRC), in which the United States President’s Emergency Plan for AIDS Relief (PEPFAR) would orient its HIV/AIDS interventions around the “PMTCT Platform,” as well as focus on the priority provinces of Kinshasa, Katanga, and Orientale. The new PEPFAR DRC strategy accelerates and expands support to health facilities offering comprehensive prevention of mother-to-child transmission of HIV (PMTCT), HIV treatment, care, and support services with strong linkages to the community, particularly services for orphans and vulnerable children (OVC) and other key populations (commercial sex workers, men who have sex with men, mine workers, and truck drivers). *Projet Intégré de VIH/SIDA au Congo* (ProVIC) has fully embraced the Strategic Pivot and this report demonstrates ProVIC’s strong commitment to using its remaining months of operation to fully implement this shift.

This Q3 report contains data that clearly documents ProVIC’s pivot, including the rapid expansion to 75 PMTCT and treatment sites in priority provinces, primarily within existing health zones, as per USAID guidance. ProVIC worked closely with *Programme National de Lutte Contre le VIH/SIDA* to design an integrated HIV/AIDS training model which reflects the pivot. Using the training modules, ProVIC trained 324 health and community workers across three provinces. In doing so, ProVIC has set the foundation for the PMTCT Platform going forward. The number of pregnant women who were counseled and tested for HIV and who learned their results (10,958) in this quarter represents an impressive 96% achievement against the project’s quarterly target.

Simultaneously, ProVIC continued its quality improvement initiatives, which are showing great promise, particularly in terms of an increase in male involvement. Further, ProVIC’s initiatives with Mentor Mothers show positive progress as the rates of women who are retained in PMTCT services has steadily increased over the year. In combination with the quality improvement initiatives, the project is seeing a growing number of pregnant women returning to health facilities (where they tested HIV positive) for delivery (56% compared with 48% in Quarter 1).

This report also shows ProVIC’s shift away from general population prevention and behavior change strategies towards a messaging focus on pregnant women, women and men of reproductive age, and youth. This shift began with an essential workshop for the development of messages and materials with USAID behavior change communication partner Communication for Change, with a focus on PMTCT.

ProVIC’s work with champion communities began to shift relative to the vision of the Strategic Pivot, and champion communities that do not currently operate in areas with ProVIC-supported health facilities will no longer be funded going forward. Sustainability actions have been moved forward as a result of the pivot, with increasing focus on integrating champion communities into health zone structures and assisting these communities in obtaining recognition as formal community organizations.

ProVIC’s counseling and testing activities have continued the transition to greater focus on integrated health facility-based testing while discontinuing community-based testing and reducing mobile testing of key populations. Of the 19,930 persons tested in Q3, 19,181 were tested in health facilities and only 749 were tested via mobile HTC services.

In Q3, ProVIC's treatment, care, and support activities were expanded and existing ProVIC-supported health facilities are now treatment sites providing life-long antiretroviral therapy for adults. In addition, six sites were identified to be pediatric treatment sites; this activity will roll out over the remainder of FY13. ProVIC also continued to provide cotrimoxazole to all people living with HIV/AIDS, as well as routine screening for tuberculosis and referrals for treatment. Quarter 3 saw an increase in the number of PLWHAs who were screened for TB (79%). Approximately 25% of suspected TB cases tested positive and all these individuals were subsequently placed on TB treatment.

At USAID's request to support other PEPFAR partners in the pivot, ProVIC is coordinating closely with United States Centers for Disease Control and Prevention (CDC) and Department of Defense (DOD) partners with regard to identification of OVC as well as provision of educational, clinical, and psychosocial support. This coordination is improving over time and will be assisted by the finalization of the grant with CARITAS, which will pay school fees for OVC, including those identified with the CDC and DOD.

In summary, Q3 was the critical transition period to the new vision of the PEPFAR Strategic Pivot across all intervention areas. The following report demonstrates in detail the progress achieved in this transition.

QUARTER 3 PROGRESS BY TECHNICAL COMPONENT

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

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

Activities and achievements

Projet Intégré de VIH/SIDA au Congo (ProVIC) implemented prevention activities according to the new United States President's Emergency Plan for AIDS Relief (PEPFAR) prevention of mother-to-child transmission of HIV (PMTCT) "Strategic Pivot." As part of efforts to strengthen prevention activities within the communities and accelerate PMTCT activities, ProVIC employed community mobilization, peer education, and other activities geared toward pregnant women and their families, women and men of reproductive age, youth, and other key populations. To effectively shift away from the general population as a prevention target, ProVIC held communications strategy trainings to build the capacity of Champion Community volunteers to raise awareness around PMTCT and HIV prevention services and behaviors in their communities. The project worked throughout the five provinces to provide information directly to key populations on available health services and HIV prevention through interpersonal communication sessions that focused on behavior change.

Activity 1: Reinforce and expand access to prevention services for key populations and other vulnerable groups

In Q3, ProVIC continued to target key populations—men who have sex with men (MSM), commercial sex workers (CSWs), truck drivers, fishermen, and mine workers—with HIV prevention messages and information about health services due to their higher risk of infection. ProVIC implemented the following activities related to the prevention of sexual transmission of HIV for key populations in current champion communities:

- MSM peer educators (125) distributed prevention messages to 137 MSM. They held group discussions and one-on-one conversations to educate their peers on the use of condoms and lubricant, availability of health services, and the process of referrals and counter-referrals.
- Community agents held group and one-on-one discussions about prevention of HIV, sexually transmitted infections (STIs), and gender-based violence (GBV) with 527 CSWs, 28 mine workers, 247 fishermen, and 400 truck drivers across the project's five provinces, always adapting the interventions to those most at risk given the specific epidemic of the province, as per PEPFAR's "know your epidemic" approach. For example, key populations in Katanga included mine workers, CSWs, and truck drivers.
- Male and female condoms were distributed to key populations during outreach activities.
- Demonstration kits were distributed to 125 MSM peer educators. The kits were adapted to the specific needs of the MSM population, with accompanying messages adapted to this target group. The kits contained visual aids depicting methods of HIV transmission and prevention, as well as ProVIC-branded bags, t-shirts, hats, and pens. The kits provide a sense of identity and purpose for peer educators, incentivizing them to stay involved and continue to engage MSM in dialogue on HIV prevention. The kits have also served as a motivational tool for peer educators by increasing their visibility and sense of pride and ownership in their community work.

- The *Programme National de Lutte Contre le VIH/SIDA* (PNLS) peer education module was improved by adding guidance on MSM peer education that was developed under ProVIC. A national consultant and communications specialist from the PNLS reviewed the training module and added chapters specific to MSM peer education. The PNLS has sent the module to experts to be revised and completed as part of the approval process.

Activity 2: Mobilize communities around PMTCT sites with high prevalence to increase demand, service utilization, and involvement of male partners

In partnership with Communication for Change (C-Change), ProVIC organized a workshop for staff and partners to build their capacity to deliver key PMTCT messages to pregnant women and their partners as part of ProVIC's efforts to ensure that behavior change communication (BCC) messages are adapted to the specific populations being targeted. The workshop was organized many months ago but was delayed for reasons outside of ProVIC's control, primarily because C-Change had to attend to other priorities before they could develop the BCC messages.

During the workshop, which was held in Kinshasa April 15–19, the 52 participating community volunteers (*Relais Communautaires*) developed communications materials, including demonstration kits, visual aids, and flashcards with key discussion points, to equip them to deliver PMTCT messages. The PMTCT-specific messaging included encouraging women to get tested for HIV and to know their HIV status, and to visit health facilities for antenatal consultation; promoting involvement of male partners; and advising HIV-positive pregnant women to give birth in a maternity ward that has PMTCT services. Messaging for HIV-positive pregnant women also emphasized the key elements of PMTCT: community outreach, testing, family planning, prevention of transmission from mother to child, and care and support. These integrated messages targeted toward pregnant women, their partners and families, and key populations aim to increase the use of health services and encourage behavior change through community interventions that focus on PMTCT, support to people living with HIV/AIDS (PLWHA), and orphans and vulnerable children (OVC), and prevention of GBV and sexual transmission of HIV. On April 10, ProVIC participated in the workshop for the launch and dissemination of national guidelines on the management of sexual and gender-based violence (SGBV) and training manuals for providers and community volunteers/peer educators on SGBV. ProVIC has worked closely with government counterparts in designing and implementing SGBV trainings for community volunteers so that the national training module content is appropriately integrated into ProVIC trainings.

C-Change and ProVIC are currently developing tools, including demonstration kits and visual aids, which will help community agents (*Acteurs Communautaires*) disseminate messages and effectively reach community members. Tools and messaging materials will be finalized and distributed to community members and health service providers at PMTCT sites in Q4.

With project interventions pivoting toward PMTCT and treatment, ProVIC identified 29 new PMTCT sites and provided a new comprehensive PMTCT training package to service providers and community agents in those sites. This training package allows ProVIC to directly link all community activities and services to pregnant women and to introduce the comprehensive care approach to all service providers and community agents through a coherent and integrated approach. The integrated PMTCT package includes communication techniques for community volunteers on HIV/AIDS, PMTCT, HIV counseling and testing (HCT), STI and GBV prevention, and family planning. Through this component of the

training, community volunteers learn to tailor HIV prevention messages to different populations through focus group discussions, door-to-door visits, and one-on-one discussions. They also learn how to effectively use visual aids to demonstrate HIV transmission and prevention methods.

In order to facilitate the implementation of project activities in the new PMTCT acceleration sites and to ensure the quality of services offered to the community, ProVIC has worked to build the capacity of health service providers at these new sites in several ways. In addition to providing the PMTCT training package to service providers, ProVIC staff and government partners trained 69 new community volunteers over the course of the third quarter: 20 in Lubumbashi, nine in Likasi, 21 in Kisangani, eight in Boma, seven in Kolwezi, and four in Kinshasa. This integrated workshop built the following skill sets of community volunteers:

- Improved knowledge of HIV/AIDS and STI and GBV prevention.
- Communication techniques and BCC skills.
- PMTCT-specific promotion of available health services, including those for HTC, PMTCT, GBV, family planning, care and support, and PLWHA.
- Correct use of data collection tools.

These trained community volunteers will hold group and one-on-one discussions, and conduct door-to-door visits to implement the following activities:

- Educational discussions with pregnant women at new PMTCT sites.
- Education of partners of pregnant women on HIV prevention and PMTCT services.
- PMTCT outreach to people of reproductive age as well as youth in high-prevalence zones in the new PMTCT sites to provide information about HIV prevention services available at PMTCT sites.
- Inclusion of gender equity messaging and information about GBV-related services in community outreach activities.

ProVIC has a number of quality control measures in place to monitor quality and effectiveness of community-led activities. As part of these measures, ProVIC requires each community volunteer and grantee to provide regular reports. Volunteers submit reports to health zones, which can assess the work being done by the volunteers and provide extra support as needed.

Activity 3: Improve youth access to HIV prevention services through peer education in and around PMTCT sites with high HIV rates

In response to the PEPFAR Strategic Pivot, community mobilization activities this quarter focused on youth and people of reproductive age, specifically targeting youth at PMTCT sites in areas with high HIV prevalence rates. Many youth, especially those with multiple sex partners, face an elevated risk of HIV. At the same time, they have limited access to information regarding HIV prevention, placing them at increased risk of infection. In Q3, community volunteers used group and one-on-one discussions, door-to-door visits, and demonstration toolkits to reach 1,848 men, 4,007 women of reproductive age, and 2,861 youth with HIV prevention messages and information about HIV prevention services available at PMTCT sites.

Activity 4: Develop an exit plan for previously developed champion communities without a local PEPFAR-supported PMTCT site

ProVIC is presently winding down all project interventions in Sud Kivu and in all Champion Community sites in the other provinces that do not have direct linkages to a PEPFAR-supported PMTCT site. In order to support sustainability of Champion Community activities that are closing down either in Fiscal Year (FY) 2013 (in Sud Kivu and Bas-Congo) or FY14 at the end of the project, ProVIC developed guidance to support 49 Champion Community sites in the transition toward sustainability. The guidance will help Champion Communities linked to PEPFAR-supported PMTCT sites align their activities with the Strategic Pivot, and it will help champion communities that do not have PMTCT sites to better integrate into health zones. As part of the transition guidance, ProVIC developed a table that provides clear steps and a timeline for both champion communities following the pivot and those being transferred to health zones. The table and transition guidance provide step-by-step instructions for each community to prepare for evaluation, obtain status as a locally recognized nongovernmental organization (NGO), and integrate into the health zone. The guidance also contains information to introduce communities to health zones, necessary agreements for signature, and final report assistance. The transition guidance will be shared with grantees and used by ProVIC staff.

Challenges during the reporting period and proposed solutions

Challenges	Proposed solutions
Delay in delivery of demonstration kits to newly trained community volunteers.	C-Change will finalize visual aids to complete the kits and distribute them to both new and experienced community volunteers.
Lack of motivation among certain community actors in champion communities that do not have PMTCT sites and which will stop receiving ProVIC support.	ProVIC has been preparing champion communities for the eventual end of funding, so this change does not come as a surprise. ProVIC will use the newly developed orientation kit to promote smooth transition of community groups into health zone structures and to obtain their official recognition as community organizations.
Infrequent use of community health services by key populations, particularly MSM and CSWs, and particularly services offered by religious institutions.	ProVIC is in discussions regarding the provision of support for “MSM-friendly” services with an experienced provider in Kinshasa so that MSM have a more acceptable and accessible place to receive services.

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

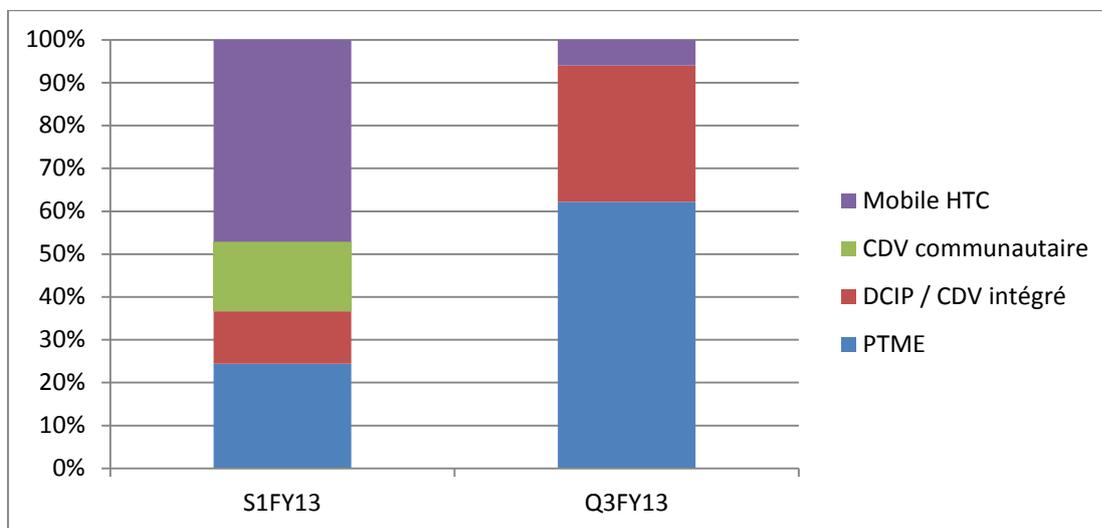
ProVIC is aligning itself with the Strategic Pivot by scaling up facility-based testing via increased PMTCT sites and provider-initiated counseling and testing (PITC), reducing mobile HTC (while improving referrals), and stopping all community-based HTC. As per United States Agency for International Development (USAID) instructions, all HTC activities stopped in Sud Kivu in Q3. ProVIC is utilizing mobile HTC services to target hard-to-reach key populations and in parallel scaling down community HTC for the general population.

Activities and achievements

During the third quarter, the project continued to scale up PITC activities and scale down voluntary counseling and testing activities in community and mobile voluntary testing centers. ProVIC is now restricting mobile HTC activities to only two partner organizations, World Production in Katanga and *Progrès Santé Sans Prix* (PSSP) in Kinshasa, to continue to build on ProVIC’s successes in targeting hard-to-reach key populations in these regions.

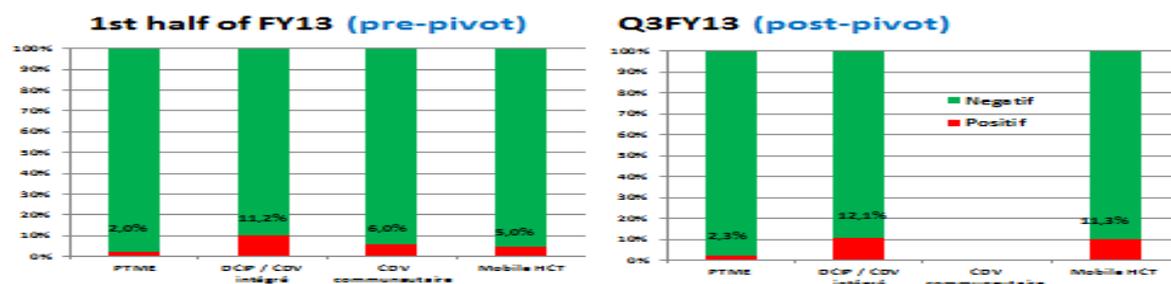
The graph below illustrates how ProVIC has been able to adapt its HIV testing approaches with the USAID strategic pivot. In Q3, mobile HTC significantly decreased while there was an increase in the percentage of people getting tested as part of the PMTCT cascade and through PITC . Of the total 19,930 clients who received counseling and testing services, 65% were through PMTCT and 32% through PICT.

Figure 1: Method of testing pre and post strategic pivot



In particular, it is important to note that mobile HTC is seems to be a better job of identifying those at-risk key populations. Previously the seropositivity rates at mobile HTC sites were being “masked” by general population being tested at these sites instead of attending health facilities as illustrated below:

Figure 2: HIV seropositivity by type of HIV testing



Activity 1: Provide high-quality HTC services to priority beneficiaries

ProVIC organized seven training sessions in four provinces: three in Katanga, two in Orientale, one in Bas-Congo, and one in Kinshasa. Using an integrated platform, these sessions brought together components of prevention and care and support according to national PNLs standards, with emphasis on PMTCT, PITC, laboratory testing, biomedical waste management, and continuum of care. The table below illustrates results for integrated HTC, disaggregated by sex and province. This data is for integrated HTC testing only, and does not include data from PMTCT testing.

Sex	HIV Status	Bas Congo	Katanga	Kinshasa	Province Orientale	Total
Women	Positive	117	344	34	28	523
	Negative	865	2,590	304	247	4,006
	Undetermined	10	15		7	32
	Sub-total	992	2,949	338	282	4,561
Men	Positive	70	220	49	27	366
	Negative	769	2,152	613	116	3,650
	Undetermined	8	10		2	20
	Sub-total	847	2,382	662	145	4,036
Total		1,839	5,331	1,000	427	8,597

Province Orientale. ProVIC tested 1,594 clients in seven care and support facilities in Province Orientale in Q3. Of those tested, 87 (5.4%). Of the 427 clients tested through integrated HTC, 55 or 13% tested positive, 51% of whom were women and 49% of whom were men.

Kinshasa. In Kinshasa, ProVIC partner PSSP offered testing and counseling services to 6,505 clients through mobile HTC services. Of these, 140 or 2% tested positive. In line with the pivot, ProVIC has been referring clients who test positive for care at facilities that are close to counseling and testing services, to ensure stronger counter-referrals and linkages between HTC and care and support services. Positive results from the use of this new strategy have been slow to emerge, but ProVIC will improve the counter-referral results in Q4 by encouraging partners to collaborate more closely with local facilities through formal and informal agreements.

ProVIC encountered a second challenge in rolling out post-pivot strategies in Kinshasa. While partners are now referring clients to care facilities that are in the neighborhood where they were tested, these facilities are not necessarily in the neighborhood where the key population clients live, so clients often do not continue to seek care from those local facilities. To decrease future rates of loss to follow-up, and ensure a continuum of care, ProVIC will strengthen the follow-up and referral systems for all key populations by assigning peer educators to accompany clients seeking services. ProVIC has trained MSM peer educators who will accompany MSM clients, and will assign previously trained peer educators to accompany client members of other key populations. The project had intended to train peer educators specific to each key population, but funding constraints did not permit this in Q3.

ProVIC will also assign focal points to organize follow-up meetings between the facilities that refer clients and the facilities that receive clients to help reduce the rate of loss to follow-up.

Finally, in following the pivot strategy, ProVIC is now restricting key population outreach services to the limits of the health zone where ProVIC supports PMTCT services. While this is the ideal strategy for the general population, it has limitations for key populations (e.g., MSM and CSWs), which are often mobile and are identified in “hot spots,” which are far from their actual residences. Referrals within health zones are also complicated when faith-based health institutions are involved, due to stigma, and, for example, the unwillingness of MSM to seek care from a Catholic hospital when much more “friendly” sites exist elsewhere.

Bas-Congo. ProVIC tested 3,464 clients in six facilities in Bas-Congo in Q3. Of these clients, 230 (6.6%) tested positive for HIV. Of the 1,839 clients tested through integrated HTC, 187 (10%) were seropositive, 63% of whom were women and 37% of whom were men.

Katanga. ProVIC tested 8,361 individuals in Katanga in Q3, of which 627 (7.4%) tested positive for HIV. ProVIC referred all HIV-positive clients for follow-up treatment, but it has been a challenge getting confirmation of successful referral. ProVIC has recognized this as a weakness in Katanga due to the transition to revised datacards for data collection.

ProVIC will immediately address data collection problems in Katanga by working closely with health zone main offices to build their capacity in data collection using the new datacards and improve coordination between health zones and the project. ProVIC will also support the PNLs to increase oversight of health facilities and hold data collection trainings to ensure accurate, timely reporting. ProVIC technical and monitoring and evaluation (M&E) staff in Katanga will build the capacity of individual service providers to collect and record data and reinforce the importance of data collection within health facilities.

Activity 2: Support the PNLs in updating the trainer’s guide on PITC and tools for data collection

The PNLs, with support from FHI 360, developed PITC normative documents which include a training module, trainer’s guide, and health care provider’s guide. At the beginning of Q3, these documents had not yet been validated by the government, so ProVIC held a workshop on April 22 and 23, during which 30 experts from the PNLs, *Programme National Multisectoriel de Lutte Contre le VIH/SIDA* (PNMLS), the University of Kinshasa, and PITC implementing partners reviewed and validated the normative documents.

Activity 3: Support the PNLs in ensuring good transfusion safety in ProVIC partner sites

ProVIC adequately supplied all PMTCT, voluntary counseling and testing, and PITC partners according to their needs and did not experience any inventory shortages. ProVIC provided testing materials for Uni-Gold™ Recombigen® HIV, Determine® HIV 1/2, and DoubleCheck HIV tests, as well as rapid plasma reagin syphilis tests and general laboratory supplies.

Activity 4: Support injection safety and biomedical waste management in all health intervention sites

ProVIC provided the following technical assistance to support biomedical waste management and injection safety at health intervention sites in the third quarter:

- Integration of PITC activities into new PMTCT sites in Katanga, Kisangani, Kinshasa, Bunia, and Bas-Congo, facilitated through integrated trainings. These trainings included modules on injection safety and biomedical waste management, such as biosafety, post-exposure accident management, waste incineration and disposal procedures, and maintaining sterile conditions during testing. All 324 health service providers and community agents who participated in the integrated PMTCT trainings also received training in biomedical waste management and injection safety.
- Provision of supplies to support biomedical waste management in health facilities, including gloves, alcohol, bleach, and disposal containers for sharp objects and other waste.
- Monitoring of biomedical waste management at health facilities during supervision visits. In collaboration with government partners and health zones, ProVIC conducted 48 supervision visits, during which staff regularly monitored and assessed biomedical waste management practices.

Challenges during the reporting period and proposed solutions

Challenges	Proposed solutions
Ensuring continuum of care for key populations, specifically MSM and CSWs, given their mobility.	Promote the involvement of health zones and facilities in the delivery of services to MSM and CSWs; foster a welcoming environment for MSM and CSWs within “friendly” health facilities.
Sustaining efforts in biomedical waste management. Although all sites have been trained and equipped, a handful of sites are not sustaining standard operating procedures with regard to biomedical waste management and will need intensified supervision.	Increase management of biomedical waste, particularly in Kisangani.

Sub-IR 1.3: PMTCT services improved

ProVIC supported the implementation of PMTCT activities at 45 sites in Q3: health centers (“spokes”) and general reference hospitals (“hubs”). At the beginning of this quarter, ProVIC continued to reorient interventions according to PEPFAR’s new recommendations. In health zones where ProVIC had already been operating, the support of PMTCT sites was reviewed, taking into consideration sites that met the criteria of having overall high volume, a high rate of seropositivity, and currently offering comprehensive HIV care and support services. ProVIC then developed a plan to gradually increase coverage of the comprehensive PMTCT package, including ART, across the health zones.

A total of 22 new PMTCT sites were identified in the current ProVIC-supported health zones as well as 22 others in the new health zones in the three provinces (Orientale, Katanga, and Kinshasa). This change will increase the total number of ProVIC-supported PMTCT sites from 31 to 75 by the next quarter. A total of 45 sites implemented activities in the third

quarter, and service providers were trained in integrated PMTCT and comprehensive care so that new sites will be operational in Q4.

Table 4. Distribution of PMTCT sites in current and new health zones.

Province	Current health zones		New health zones	Total sites proposed
	Existing sites	New sites	New sites	
Kinshasa	5	5	0	10
Katanga	14	15	9	38
Orientale	6	2	13	21
Bas-Congo	6	0	0	6
Total	31	22	22	75

During the reporting period, ProVIC continued to use innovative approaches to ensure the quality of services for PMTCT. This included (1) piloting University Research Co., LLC’s (URC) “Improvement Collaborative” methods for quality assurance and improvement in Kinshasa maternities, which was extended to four Kisangani PMTCT sites; (2) piloting the Elizabeth Glaser Pediatric AIDS Foundation Mentor Mothers approach in using trained peer counselors during the PMTCT service delivery process in six sites; and (3) experimenting with the performance-based financing (PBF) model focused on PMTCT services at *Centre Hospitalier (CH) Kikimi* in Kinshasa. The team also continued to conduct routine and targeted supervision visits to further improve service quality and site performance.

ProVIC collaborated actively with the Ministry of Health (MOH) through the PNLs, *Programme National de Santé de la Reproduction*, the Department of Maternal and Child Health, and provincial health teams in Q3 by offering suggestions and constructive feedback to ensure alignment of project-supported PMTCT activities with national standards. ProVIC also worked closely with other PEPFAR implementing partners and the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) to harmonize interventions on the ground and to develop the Option B+ transition plan. The USAID health team conducted supervision visits to ProVIC-supported sites to verify the implementation of PEPFAR’s new strategic guidance.

ProVIC’s PMTCT Q3 FY13 target was to reach 11,457 pregnant women with PITC and to provide antiretroviral medications (ARVs) to 264 HIV-positive pregnant women to reduce the risk of mother-to-child transmission (considering an average seropositivity level of 1.6% in ProVIC sites in 2012). To this end, ProVIC reached 10,958 women with counseling and testing services (96% of target) and provided 286 HIV-positive women with ARVs to reduce the risk of mother-to-child transmission.

Activities and achievements

Activity 1: Complete the package of comprehensive PMTCT services at ProVIC sites

During Q3, ProVIC continued to provide HIV-positive pregnant women and their families with high-quality services, including prevention, care, support, and treatment, although HTC was stopped in Sud Kivu at the instruction of USAID.

ProVIC made a commitment to complete the PMTCT package in spokes and hubs in accordance with PEPFAR orientations and in alignment with national standards and policies. This integrated package takes into account: (1) community activities carried out through

sensitization messages¹ provided by community workers to support male partner involvement, and to encourage pregnant women to seek early antenatal care (ANC) (in the first quarter of their pregnancy), complete all four ANC visits, and follow up on their children's under-five care; and (2) health facility activities to reduce mother-to-child transmission of HIV, which consisted of providing:

- PITC to pregnant women and their male partners, including initiating HIV-positive people on ART, in accordance with the national protocol in use on either prophylaxis or treatment.
- Maternal and child health services to prevent factors that increase mother-to-child transmission risk, such as syphilis screening and treatment, SGBV and tuberculosis (TB) screening, referral/counter-referral for positive cases, malaria prevention, and nutrition screening.
- Support groups for HIV-positive women and their families to reinforce retention and adherence (Mentor Mother support groups at PMTCT sites or community support groups), and follow-up of mother-child pairs, including early infant diagnosis, cotrimoxazole within two months of birth, and ART for infected children.

At the hubs, this package is completed through CD4 count and provision of care for the major side effects of ART.

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

In this quarter, ProVIC continued to implement PEPFAR's Strategic Pivot recommendations and committed itself to increasing PMTCT coverage within current health zones by taking into account sites reflecting higher HIV prevalence and higher attendance by pregnant women. In accordance with these criteria, ProVIC decreased the number of current sites to be supported from 44 to 31. Those sites which will no longer have ProVIC support received a transition plan to make sure HIV-positive women would be referred to Global Fund-supported sites. A needs assessment was conducted to identify 22 new sites in the same health zones. ProVIC then implemented the complete package of PMTCT services as required at spokes and the additional package in existing hubs prior to extending project support to 22 new sites identified in current intervention health zones located in Kinshasa, Orientale, and Katanga. A training plan for providers was developed in collaboration with the PNLs in May and June. During the same period, work on commodities quantification was completed, and a site supply plan was updated. New sites will start activities in Q4. In the meantime, ProVIC continued PMTCT activities in Bas-Congo without planning for the addition of new PMTCT sites and also continued to support Sud Kivu in the development of its transition plan to end activities in September 2013, based on USAID's decision.

To reach targets in some 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.

Activity 3: Expand the package of PMTCT services into new health zones

¹ These messages were developed and standardized by ProVIC in partnership with C-Change.

The last plan developed during the period concerned the extension of PMTCT service coverage in four new health zones, two in Orientale (Mangobo and Bunia) and two in Katanga (Kamina and Bukama). The peer-to-peer approach running between spokes and hubs, particularly for CD4 count analysis and care for major ART-related side effects, was implemented in those health zones.

Table 5. Phased PMTCT roll out for all sites.

Activity	Sites	Q2			Q3			Q4		
Needs assessment	New sites (1)									
	New sites (2)									
Training	New sites (1)									
	New sites (2)									
Commodities	New sites (1)									
	New sites (2)									
Start up	New sites (1)									
	New sites (2)									

New sites (1): in current health zones. New sites (2): in new health zones.

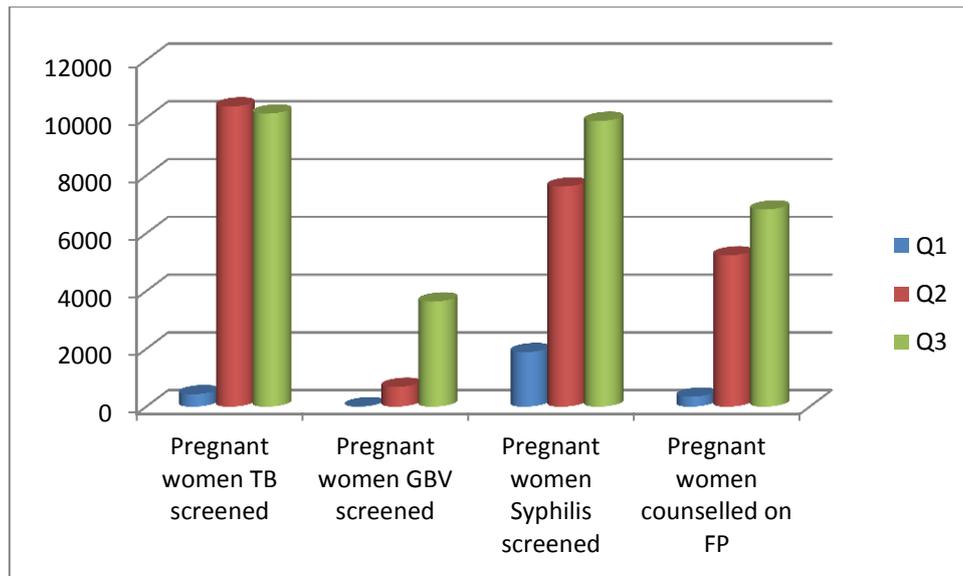
Activity 4: Develop and strengthen linkages to care and support and treatment services for HIV-positive pregnant women, their families, and OVC

In Q3, ProVIC continued to engage at numerous levels to strengthen the continuum of care for HIV-positive pregnant women and their families by strengthening linkages to care and support, and to integrate PMTCT activities into maternal and child health services. Therefore, all pregnant women attending a facility should receive family planning counseling, syphilis testing and treatment (in case of positive results), SGBV screening and support or referral to specialized treatment units, and TB screening and referral and treatment initiation (in case of positive confirmation of TB infection). HIV-positive women and their families were referred to support groups led by Mentor Mothers or to facility-based social workers for psychosocial support and/or for required medical attention, according to the needs of each client.

HIV-exposed children on nevirapine prophylaxis at birth, following national protocol, were followed up for immunizations, early testing, cotrimoxazole initiation at six months after birth, and recommendations regarding breastfeeding. In all PMTCT sites, in addition to phone calls from providers to pregnant women and home visits for those who had not shown up to their appointments, other strategies, such as covering maternity fees for HIV-positive women, were used to reduce loss to follow-up.

Using the tool developed in Q2 that includes all indicators for ProVIC's integrated activities in the continuum of care, ProVIC increased the number of pregnant women and their families receiving services along the continuum of care and support in PMTCT sites, but an effort will be made to offer these services to 100% of pregnant women and their families.

Figure 4. Progression of continuum of care indicators from Q1 to Q3.



Activity 5: Ensure coaching and mentorship for integrated PMTCT services offered through the “PMTCT Platform”

ProVIC created a management tool in Q3 that allows for the coordination of comprehensive PMTCT activities, which are a complex set of interventions that take place at multiple levels of the health care system. ProVIC teams developed a list of indicators that highlight aspects of integrated, comprehensive PMTCT services. These indicators will highlight strengths and weaknesses in the provision of comprehensive integrated services and will lead to improved decision-making to strengthen identified weaknesses (through capacity-building activities that include coaching, mentoring, and site supervision). These meetings contributed to improving retention in the continuum of care offered in the PMTCT sites as described in Activity 4 above. However, these meetings were often widely spaced apart, and it is recommended that they occur more regularly in Q4 to actually center interventions for pregnant women.

Activity 6: Pilot innovative approaches

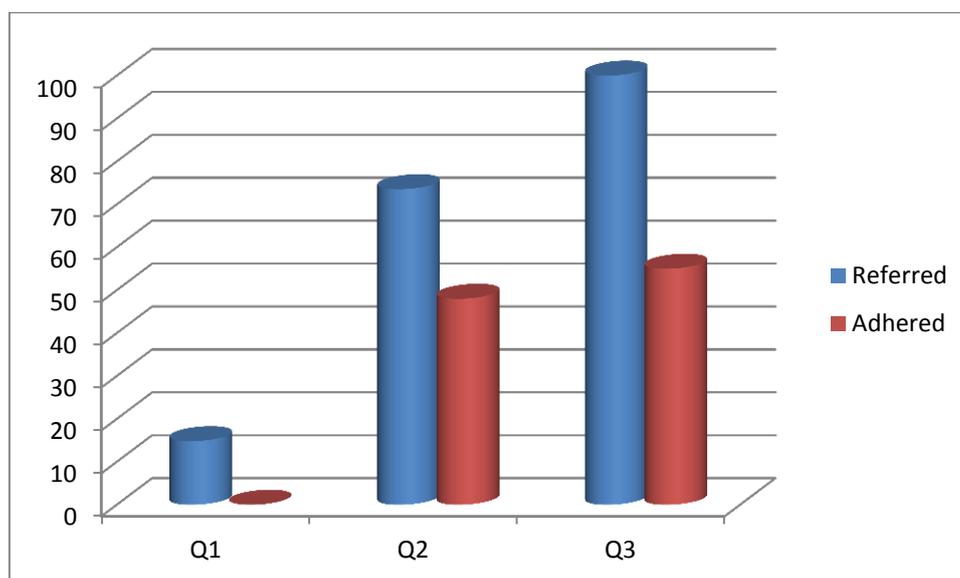
The Mentor Mother approach. To improve the adherence and retention of HIV-positive pregnant women in PMTCT services, ProVIC targeted six PMTCT sites in Kinshasa, Katanga, and Orientale to pilot the Mentor Mother approach.

During the reporting period, the trained Mentor Mothers started coaching HIV-positive women through support group meetings conducted at health facilities under supervision of providers and health zone senior staff. They also conducted home visits to track women lost to follow-up. The integration of PMTCT, care, and support activities reinforces the capacity of Mentor Mothers regarding the positive prevention package. Those activities ran successfully in Kinshasa and Province Orientale, where Mentor Mothers’ husbands encouraged their wives in their work. Mentor Mothers helped many newly diagnosed HIV-positive women more easily accept their status and to come with their husbands to health facilities. PMTCT support groups extended to include male partners and children. There were challenges in conducting home visits to HIV-positive women living outside of health zones.

The figure below shows data from Orientale on the improvement in the rate of HIV-positive pregnant women referred to support groups by providers and those who accepted care and

support services through these support groups with accompanying Mentors Mothers. In the beginning of this year, the rate was very low but has increased substantially.

Figure 5 . HIV-positive pregnant women referred to and adhered in support groups.



PBF at CH Kikimi. In collaboration with both the government of the Democratic Republic of Congo (DRC MOH Secretary General) and USAID, ProVIC launched its first PBF for the PMTCT pilot at CH Kikimi in Kinshasa at the end of Q2. During this quarter, CH Kikimi focused on quality improvement of PMTCT services, including work on a location for education messages, a counseling corner, and a room for ANC visits . This will help improve the client flow of pregnant women during ANC visits because they will receive all necessary services at the same location and will not have to travel long distances, which, more often than not, results in loss to follow-up. The PMTCT team coached the Kikimi team on development of a business plan and the preparation for administrative and community verification required after three months of work.

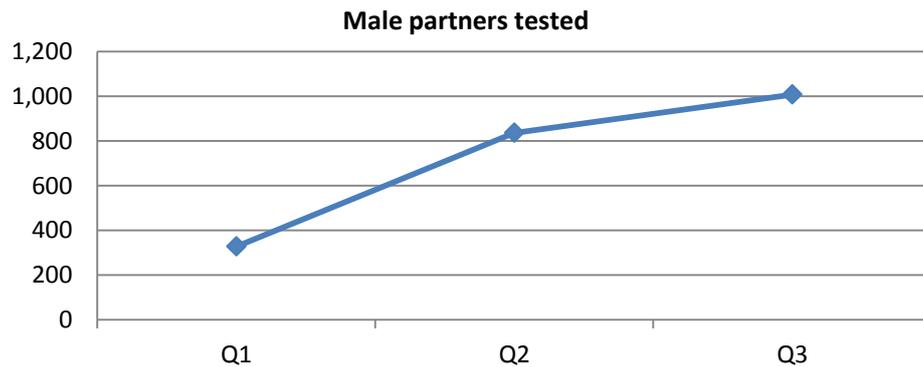


Coaching of teams at health facility

Rollout of URC's quality assurance and improvement approach at 14 ProVIC-supported maternities. Two main activities were carried out in Q3:

1. Mentorship/Coaching visits were conducted by the government and ProVIC coaches to maintain the benefits acquired during the demonstration phase in the four Kinshasa maternities, as recommended in the first session organized in Q2. One example of these benefits is an increase in male partner involvement, as shown in the figure below.

Figure 4. Improvement in male partner testing in four maternities in Kinshasa.

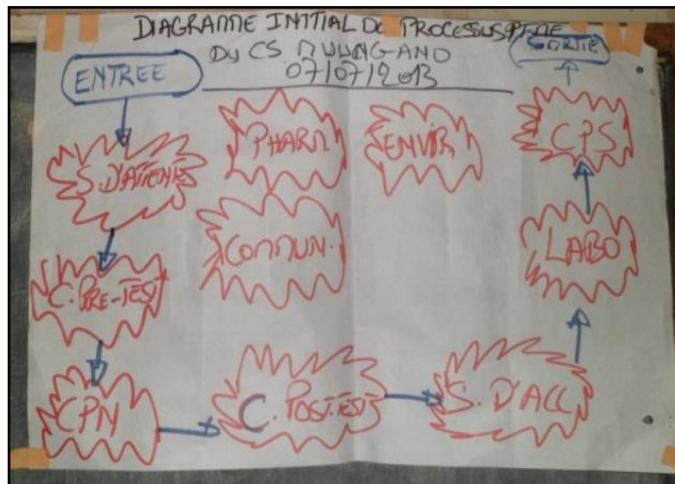


2. The quality improvement collaborative approach was extended in four maternities offering PMTCT services in Kisangani. Four quality improvement teams were organized and 20 coaches (from the PNLs, *Equipe Cadre de Zone de Santé*, DPS, and ProVIC) were trained to coach the teams. After the assessment regarding the quality of services in these maternities, each team developed an initial diagram that represented the PMTCT process. Steps in the PMTCT process that were not in accordance with national standards were drawn as clouds, and the steps that were in accordance with national standards were drawn as rectangles. The photo to the right provides an example of the diagrams.

Aware of the challenges, the quality improvement teams will implement ideas to improve the quality of services. After three months, the teams will meet to analyze the changes in performance. This will result in a package of ideas to be extended to new facilities.

Activity 7: Reinforce the capacity of the government at all levels to provide comprehensive PMTCT services

ProVIC actively participated in meetings organized by the MOH in Q3, including the Technical Working Group and Maternal, Newborn, and Child Health Task Force, offering suggestions and constructive feedback on challenges raised in the groups. ProVIC also helped validate national ARV and Option B+ standards, guidelines, and newly integrated tools. In addition, the project collaborated with the MOH at the national level and with the technical support of C-Change to update the national PMTCT messages used in communities and in illustrative flip charts at the site level.



Initial diagram of PMTCT process at CS Muungano in Kisangani.

Evolution of PMTCT cascade indicators during Q3 FY13

PMTCT cascade indicator	Katanga	Kinshasa	Orientale	Bas-Congo	Total ProVIC	Performance (%)
Number of pregnant women attending ANC	3,376	4,178	872	1,582	10,008	
Number of pregnant women counseled during ANC services	3,376	4,178	872	1,582	10,008	100%
Number of pregnant women counseled during labor and delivery services	506	839	101	186	1,632	15%
Total number of pregnant women counseled	3,882	5,017	973	1,768	11,640	
Total number of pregnant women tested for HIV and who received their results (ANC and labor and delivery)	3,619	4,864	872	1,505	10,860	
Number of known positives at entry (ANC and labor and delivery)	34	40	2	22	98	
Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results) + known positives at entry (P1.1D)	3,653	4,904	874	1,527	10,958	94%
Total number of women tested at the facility (ANC and labor and delivery) who received HIV-positive test result	127	59	23	37	246	
Seropositivity (percentage of women of unknown status who were tested and found to be positive)	3.5%	1.2%	2.6%	2.4%	2.2%	
HIV-positive pregnant women						
Total number of HIV-positive women (ANC and labor and delivery)	161	99	25	59	344	
Total number of women tested for CD4 count during ANC and labor and delivery services	113	99	19	46	277	81%
Percentage of HIV-positive pregnant women who received ARVs to reduce the risk of mother-to-child transmission (P1.2D)	113	99	23	51	286	83%
Total number of women on zidovudine prophylaxis	70	59	18	42	189	55%
Total number of women on ART	43	45	5	9	102	30%
Number of pregnant women with advanced HIV infection newly enrolled on ART (contribution to T1.1D²)	31	45	4	4	84	
Total number of HIV-positive women on cotrimoxazole	95	97	21	67	280	81%
Exposed infants						
Total number of HIV-positive women who delivered in a maternity	77	56	16	41	190	56%
Number of infants born to HIV-positive mothers on ART for PMTCT	77	56	16	41	190	100%
Number of infants born to HIV-positive women who received an HIV test within 12 months of birth (C4.1D)	44	55	3	14	116	34%
Number of infants born to HIV-positive women started on cotrimoxazole	29	55	2	5	91	26%

² The indicator also shows other elements. Here we show the contribution from pregnant women.

PMTCT cascade indicator	Katanga	Kinshasa	Orientale	Bas-Congo	Total ProVIC	Performance (%)
prophylaxis within two months of birth (C4.2D)						
Male partners						
Number of male partners tested	218	1,008	238	175	1,639	15%
Number of male partners who tested positive for HIV	10	3	5	10	28	
Seropositivity	4.6%	0.3%	2.1%	5.7%	1.7%	
Total HIV-positive male partners tested for CD4 count	5	2	5	2	14	
Total HIV-positive male partners with CD4 \leq 350	1	1	0	2	4	
Total HIV-positive male partners on cotrimoxazole	10	2	5	3	20	
Total HIV-positive male partners on ART	1	1	0	0	2	
Total male partners treated for syphilis	0	5	33	9	47	
Other family members tested for HIV	30	23	2	0	55	
Other family members who tested positive for HIV	4	0	0	0	4	

The following trends were observed from Q3 data:

- A total of 10,008 pregnant women received HIV counseling at ANC and 1,632 at labor and delivery. Thus, 15% of ProVIC clients presented first at labor and delivery. Of the total 11,640 pregnant women counseled, 10,958 women (94%) learned their HIV status (this includes 10,860 women who were tested for HIV and received their results and 98 known positives at entry).
- A total of 344 pregnant women who received PMTCT services were HIV positive; of these, 246 were newly diagnosed as HIV positive by ProVIC and 98 presented with known HIV-positive status. These results reflect a general seropositivity of 2.2% among pregnant women who accepted HIV testing at ProVIC sites. The differences were 3.5% in Katanga, 2.6% in Orientale, and 2.4% in Bas-Congo.
- Of the 344 HIV-positive pregnant women mentioned above, a total of 286 HIV-positive women (83%) were initiated on either ARVs for PMTCT or ART for life based on CD4 testing or WHO staging.
- In Q3, 190 HIV-positive pregnant women delivered at ProVIC-supported PMTCT sites, and 190 infants (100%) born to HIV-positive mothers received ARV prophylaxis to prevent HIV transmission during the recommended breastfeeding period.
- Early infant diagnosis of 124 HIV-exposed infants was conducted in Q3, and 94 infants were initiated on cotrimoxazole prophylaxis.
- A total of 1,639 male partners (15%) were counseled and tested for HIV and received their results. Of these, 28 were HIV positive, reflecting a seropositivity rate of 1.7% among male partners of ANC clients who had accepted an invitation to visit the ANC site. Four out of 14 men who received CD4 count testing were treatment eligible, and two of these four treatment-eligible men were placed on ART. A total of 20 male partners were placed on cotrimoxazole prophylaxis.
- In all, 55 other family members were tested for HIV, of which four tested HIV positive and ineligible for treatment, but were started on cotrimoxazole.

These results are encouraging and show the quality improvement of PMTCT services provided in ProVIC-supported sites.

ProVIC continued to work attentively with partners and health zones over the third quarter to improve the quality of these services and to coach providers through the disclosure process.

These overall strong results also show the positive effects of innovative approaches such as the Mentor Mother approach and the quality improvement approach. These two approaches contributed to the retention of HIV-positive pregnant women in the PMTCT program as evidenced by the growing number of pregnant women returning to health facilities for delivery and by the increased involvement of male partners.

In addition, the number of pregnant women who were counseled and tested for HIV and who learned their results (10,958) represents an impressive 96% achievement against the project's quarter target (11,456).

The proportion of HIV-positive pregnant women on ARVs (83%) is perhaps lower than expected and is largely due to incomplete data from Katanga. In other provinces, such as Kinshasa, 100% of pregnant women were put on ARVs, for the reduction of mother-to-child

transmission was 100%). HIV-positive pregnant women with a CD4 count ≤ 350 were put on life-long ART for their health. ARV treatment for eligible pregnant women began in Q3 at all PMTCT sites.

The return rate of HIV-positive pregnant women to deliver at the PMTCT facility where they were tested has increased to 56%, compared to 48% in the first quarter. The women remaining in the support groups run by the Mentor Mothers learn to accept their serological status, to share their status with their partners, and to take advantage of all the services they and their families need. The assessment of the Mentor Mother approach that will be conducted in Q4 will give more details on the results achieved by this approach.

It should be noted that Mentor Mother activities are taking place at only six sites and that Katanga Province has experienced difficulties in the implementation of the approach, where three out of the four Mentor Mothers have become pregnant, and are thus unable to effectively offer the services expected of them. Also, ProVIC has continued to strengthen the collaboration and linkages between PMTCT sites and self-help groups to improve adherence by, and retention of, HIV-positive women.

Early screening of exposed infants is already well managed by providers, as is the initiation of exposed infants on cotrimoxazole at six weeks old. These indicators appear weak in the cascade due to incomplete data.

Male involvement in PMTCT continued to improve through the mechanisms implemented by quality improvement teams mainly in Kinshasa, where we noted that of a total of 1,639 male partners for all ProVIC-supported sites, 1,008 were tested in Kinshasa, where quality improvement activities were implemented. The 15% of male partners reached is a high rate, greatly exceeding the national rate. The quality assurance/improvement activities resulted in increased male involvement, to 15% in Q3 from 5% in the first quarter of Year 4 and 8% in the second quarter. The services offered to male partners continue to improve. Male partners are immunologically evaluated and put on ARVs if eligible. Ineligible individuals receive cotrimoxazole.

The screening of other family members of HIV-positive pregnant women also improved over the first two quarters, as well as the provision of care and support to these family members.

Analysis of continuum of care in PMTCT sites in Q3 Table 6 shows that during ANC services, 9,655 pregnant women were tested for syphilis, and 82 positive cases were identified and treated along with their male partners, according to the PNLS guidelines. A total of 9,970 pregnant women (both HIV positive and negative) were screened for TB, of which two cases of TB/HIV co-infection were found. A total of 3,639 pregnant women (both HIV positive and negative) were screened for SGBV (just in Kinshasa and Orientale). And 5,911 women were counseled on family planning methods.

Table 6. Continuum of care for all PMTCT clients.

Target	Interventions					
	PITC	Family planning counseling	Syphilis screening	Syphilis treatment	TB screening	GBV screening
Pregnant women	17,714	5,911	9,655	82	9,970	3,639
Male partners	1,675			50		
Other family members	55					

Table 7 shows how individuals who tested HIV positive are benefiting from the continuum of care services and support package. The overall number of beneficiaries, while still low, is nonetheless encouraging, since ProVIC initiated efforts to develop linkages between PMTCT services and care, treatment, and support services only in the second quarter of this project year.

Table 7. Continuum of care for HIV-positive individuals.

Target (HIV positive)	Total	Interventions									
		CD4	CTX	AZT	ARV	NVP	EID	Pediatric Treatment	FP	APS	NACS
Pregnant women	320	248	287	169	118				57	150	421
Male partners	30	15	22		2						
Infants	199		89			199	119	0			
Other family members	4	4	4		0			0			

APS: Psychosocial support; **AZT:** zidovudine; **EID:** early infant diagnosis; **FP:** family planning; **NACS:** nutrition assessment, counseling, and support; **NVP:** nevirapine; **TARV:** ARV

Based on these achievements, ProVIC, in providing support in the implementation of comprehensive PMTCT activities, including treatment of eligible individuals, aligns with the family approach advocated by the DRC government and contributes to the achievement of the objective of an “AIDS-free generation.”

Challenges during the reporting period and proposed solutions

Challenges	Proposed solutions
Integrating the care and support package into new PMTCT sites to extend the continuum of care.	<ul style="list-style-type: none"> Build the capacity of providers during site visits. Supply commodities for HTC activities (Determine[®] HIV 1/2 tests). Supply commodities for continuum of care services. Develop efficient referral and counter-referral systems between health facilities and support groups.
Coordinating activities within the PMTCT component.	<ul style="list-style-type: none"> Develop an integrated tool for PMTCT teams to help follow up the continuum of care package. Enhance linkages and working meetings between the PMTCT, care, treatment, and support components.

Challenges	Proposed solutions
Stopping counseling and testing services in Sud Kivu without formal communication between the province and the United States government.	<ul style="list-style-type: none"> ProVIC met with USAID to express this concern. We would like to request again that USAID formally communicate with Sud Kivu on discontinuing testing, as well as ProVIC's withdrawal at the end of FY13. This will be necessary for the labor inspectors as well as the withdrawal of sensitive materials such as the PIMA™ Analysers, which we understand USAID would like us to transfer to other health zones in priority provinces.

Activities planned for the next quarter 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 HTC services enhanced</i>	Sub-IR 1.3 <i>PMTCT services improved</i>
Finalize HIV prevention visual aids.	Supply HTC and PITC facilities with materials to support biomedical waste management and biological analysis.	Implement the start-up of comprehensive PMTCT activities in news sites and ongoing supervision in the existing sites (strengthening linkages within PMTCT, care and support, and treatment services).
Produce and distribute communications materials featuring key PMTCT messaging.	Provide HTC, PITC, and PMTCT facilities with testing and biological monitoring materials.	Evaluate and document the new innovative approaches implemented in FY13 (Mentor Mothers, quality assurance/improvement, and PBF model).
Monitor and evaluate Year 4 health zone Champion Community activities and organize graduation ceremonies for communities achieving Champion Community status.	Conduct quality assurance in PMTCT partner facilities.	Provide coaching and mentoring on integration of PMTCT, treatment, and continuum of care activities through the PMTCT comprehensive platform.
Hold BCC sessions for key populations and youth and direct them to community health services, to both reduce their risk of infection and transmission and minimize stigmatization.		

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

Sub-IR 2.1: Care and support for PLWHA strengthened

Key achievements

Overall in Q3, 64% of PLWHA received cotrimoxazole. Low rates were seen in Katanga and Orientale, due to the fact that PLWHA had been used to receiving cotrimoxazole in the community and some struggled to adapt to receiving the drug only from a clinic or hospital. Further, some patients were advised to stop taking cotrimoxazole. A total of 79% of PLWHA were screened for TB, with a high number of them coming from members of self-help groups; 100% of those who tested positive received treatment, marking a significant improvement over the first half of the year, which recorded only 68% of TB positive PLWHAs getting treatment.

A total of 1,292 PLWHA received nutritional support in three provinces (Bas-Congo, Kinshasa, and Katanga), while 1,471 benefited from positive prevention and 1,121 individuals newly tested HIV positive were referred for care/pre-ART or ART services. More and more PLWHA are receiving the positive prevention package of services in clinical settings. The self-help group integration strategy with health facilities was marked by the formation of 71 self-help groups (five PMTCT and 66 mixed).



Work session with a nurse during maternal follow-up/care and support in Kinshasa.

Activity 1: Early identification of HIV-positive individuals among pregnant women, partners, children, most at-risk populations, PITC clients, and youth at risk, and linkage to and retention in care

A key focus this quarter has been on setting up the PMTCT-focused self-help groups facilitated by the Mentor Mothers and ensuring that they are linked to the existing community-level groups. The self-help groups have been supported through the provision of referral and counter-referral tools. The tools were provided in collaboration with the PNMLS and include the referral and counter-referral guide and forms for implementing partners to refer clients to health facilities as needed and to ensure they receive the correct documents for counter-referral.

As reported under previous intermediate results, in Q3, extensive integrated training was completed in multiple provinces by ProVIC staff for multiple stakeholders, including the central health zone offices, service providers, and health focal points.

Work was also done to increase the number of pregnant women who tested positive being referred to self-help groups. This included working with the groups on the continuum of care

within the PMTCT cascade. As a result, increased numbers of pregnant women have been retained within the continuum of care and have been able to access the minimum package of care, such as provision of cotrimoxazole, CD4 count testing, diagnosis and treatment of malnutrition, diagnosis and treatment of TB, access to positive prevention messages and activities, and access to ARVs. Self-help groups have worked with and counseled partners of HIV-positive women as well as their children to increase testing for HIV and to increase screening for TB.



Follow-up to care and support activities in Binza Meteo (Kinshasa).

Table 8. Functional PMTCT and mixed self-help groups formed in Q3.

Province	PMTCT	Mixed
Katanga	0	8
Bas-Congo	2	6
Kinshasa	3	15
Sud Kivu	0	37
Total	5	66

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

A key focus of Q3 was on extensive integrated PMTCT training with 75 providers at PMTCT sites, including doctors, nurses, community volunteers, pharmacists, pharmacy clerks, laboratory technicians, and social workers in Kinshasa, Katanga, Kisangani, Boma, and Bunia. The training included sessions on PMTCT, ART, Options A, B, and B+, the management of STIs and opportunistic infections, psychosocial support, management of inputs and medicines, and biological monitoring. The objective of the training was to ensure that all actors in the continuum of care were trained collectively to ensure improved integration and coordination and an understanding of the continuum of care and linkages between the community and health facilities.

Cotrimoxazole is part of the minimum package of care, and its importance has been covered as part of the integrated training with self-help groups. ProVIC has worked with the Supply Chain Management System (SCMS) project to supply all health service providers in the PMTCT sites with cotrimoxazole. Provision of the drug within the clinical setting allows for better management of side effects. During follow-up visits to sites and grantees, it was found that all PLWHA who received cotrimoxazole had received it at a health facility. However, it has been observed that stigma and discrimination and transport issues do have an impact on the willingness of PLWHA to seek care at a clinic.

In this quarter, ProVIC continued to emphasize efforts to screen and refer PLWHA for treatment of TB. To do this, within PMTCT sites and within the community, ProVIC has made available a TB screening tool to assist self-help groups with referral for TB testing, and these groups continue to play a role in screening for TB among their members. Within the clinical setting, medical consultations are utilized to proactively test for TB. In Q3, all PLWHAs suspected of TB (based on initial screening) were referred for TB testing. Approximately 25% of those tested for TB tested positive. All PLWHAs that tested positive for TB were subsequently placed on TB treatment.

Promoting nutritional counseling is intended to be a routine activity within health structures, and PLWHA in general and pregnant and lactating women are key targets. However, nutritional counseling is not yet consistent in all health facilities. To counter this, self-help group meetings have concentrated on providing nutritional counseling through Mentor Mothers, caregivers, and social workers in order to reach a greater number of PLWHA. A total of 1,292 PLWHA and OVC benefited from nutritional support in Q3. However, lack of therapeutic food and insufficient supplies in government nutritional units hamper the efforts to address the issue of malnutrition of PLWHA.



Social workers from Katanga receiving their training certificates.

Activity 3: Improve the quality of life of PLWHA

A workshop to develop educational support materials on PMTCT took place in Q3, facilitated by C-Change. The image boxes produced during the workshop were shared with ProVIC for feedback. C-Change will integrate feedback and produce the final version, which will then be shared with all PMTCT sites.



A group of doctors and nurses engage in a role play during training in Katanga.

Working in collaboration with Livelihood and Food Security

Technical Assistance, ProVIC has been shifting its household economic strengthening model from income generation activities to internal/voluntary savings and loan models. Presently, 18 savings and loan groups are in place, of which ten are fully operational.

Challenges during the reporting period and proposed solutions

Challenges	Proposed solutions
Inconsistent supply of PIMA™ reagents.	Work closely with SCMS to anticipate and manage stock ruptures.

Sub-IR 2.2: Care and support for OVC strengthened

Work in Q3 has mainly concentrated on the process of requalification of OVC and ensuring that existing OVC are included in the PMTCT cascade and accessing educational and vocational support.

OVC data analysis revealed some challenges with the initial cohort of OVC picked up by ProVIC (e.g., inconsistent use of selection criteria). Therefore, reassessment began in Q3 to requalify the current cohort of OVC in the three priority provinces in order to correctly ascertain the status and levels of vulnerability of each OVC. This work will continue into Q4. In line with the ProVIC PMTCT strategy, the project initiated the identification and registration of OVC in PMTCT sites. In the first half of this year, 478 pregnant women tested positive (in Kinshasa, Katanga, Bas-Congo, and Orientale Province). At each PMTCT site, Mentors Mothers, care and support focal points, and social workers have been working closely to identify and register the children of HIV-positive women.

Following USAID’s recommendation in relation to care and support provided to OVC under the United States Centers for Disease Control and Prevention (CDC) and Department of Defense (DOD), ProVIC initiated consultation meetings in Q3 with the implementing partners of these two agencies, which led to the validation of a joint form for identifying OVC.

In Kisangani, ProVIC identified 140 ASF, Population Services International, and University of North Carolina partner OVC. These OVC are to be enrolled in the program to benefit from the package of services according to their needs. ProVIC will follow the same process in Q4 in Katanga, Kinshasa, and Kisangani.

A project to increase the number of OVC receiving school support was designed and finalized with local NGO CARITAS, which will change the strategy by which ProVIC supports OVC needing school support. This project has been submitted to USAID for approval.

Activity 1: Support families of eligible OVC to improve the overall health of OVC

Recognizing that children and their families play an important role in improving family health, ProVIC, in partnership with C-Change, developed key messages on child and infant health and well-being. These messages will be used as counseling and education tools for service providers, including social workers, to develop the skills of children and their guardians.

Children from families who participate in child-to-child (C2C) groups receive key health messages covering topics such as waterborne diseases, malaria, and the importance of using impregnated mosquito nets and maintaining a clean environment. Through referrals to medical structures, 381 OVC received medical care.

Finally, by piloting the approach of strengthening household economies through volunteer savings and loan associations, the potential of families to financially support the overall health of their children is being improved. This is being reinforced by *mutuels de santé* (health insurance cooperatives) and links to ProVIC-supported health facilities in order to support the most financially vulnerable families.

Activity 2: Provide prevention services and support to eligible HIV-positive and -negative OVC

All HIV-positive OVC have access to the minimum package of clinical services. C2C groups focus on HIV prevention and support for children to understand how to care for and support parents or family members living with HIV. Dissemination of the C2C manual and provision of support to the groups continued in Q3.

Activity 3: Provide clinical services to HIV-positive OVC

This has been incorporated into Sub-IR 1.3.

Activity 4: Improve the nutritional status of OVC

See Sub-IR 2.1.

Activity 5: Support OVC completion of primary school and emphasize support for female OVC to access secondary school

ProVIC facilitated access to school support or vocational training for 2,092 OVC in Q3. As required by PEPFAR, priority was given to OVC in the final stages of primary education, which represented more than 65% of the total number of OVC assessed.

In addition, with the objective of increasing the number of OVC enrolled for next year, ProVIC submitted to USAID a partnership project with CARITAS, which will enable easier access to education for 5,850 OVC in three priority provinces (Kinshasa, Katanga, and Orientale). The project will move to the implementation phase in Q4, when the school year commences.

Challenges during the reporting period and proposed solutions

Challenges	Proposed solutions
Coordination with the CDC and DOD to support their OVC. As this was not part of the original ProVIC FY13 work plan, this has resulted in resource challenges (work load and financial)	ProVIC continues to work with USAID, the CDC, the DOD, and their partners to support OVC. Communication and coordination, particularly with regard to educational support, improved this quarter and should lead to results for the new school year.

Sub-IR 2.3: HIV treatment improved in target areas

The USAID Strategic Pivot has led to the addition of this new Sub-IR, which adds key activities as part of the overall focus on pregnant women, their children, and family members, and effectively redefines ProVIC as a treatment program with a PMTCT focus.

In addition to the activities already integrated into the program, such as early infant diagnosis, cotrimoxazole prophylaxis, and the use of ARVs for pregnant women, their male partners, and exposed children during the PMTCT period (from the confirmation of pregnancy in HIV-positive women until complete weaning), ProVIC extended its interventions for care and support to include life-long ART for all PLWHA identified in the program. Thus, the gateway to life-long care and treatment was extended in Q3 to all PLWHA in key populations, patients who frequent the sites or who are hospitalized, and malnourished children located in ProVIC-supported health zones.

Activity 1: Conduct a baseline study of PMTCT sites to identify and integrate treatment-related services

To determine the existing HIV treatment interventions and stakeholders in the PMTCT sites, a baseline assessment was completed to address gaps in services related to ART and to ensure the integration of activities and the continuum of care for PLWHA who will be put on treatment. This assessment was essential to the development of ProVIC's contractual agreements with health facilities to finance these activities.

ProVIC administered questionnaires designed to collect key information regarding HIV treatment especially pediatric treatment. These questionnaires were sent to *Hôpital Général de Référence* (HGR) Kenya, HGR Sendwe, HGR Panda, and HGR Kasumbalesa in Katanga; *Centre de Santé de Référence* (CSR) Mokili in Kisangani; and CH Kikimi and CH Kingasani (including the maternity ward) in Kinshasa. The findings showed that all seven sites are offering ART for adults, but they are no longer providing ART to children due to a lack of pediatric ARVs. Biochemistry tests are not being performed at *Centre de Santé* (CS) Kasumbalesa. The cost of related health services was found to be substantial, with the fee for hepatic and renal analysis at US\$28 per patient and the cost for a ten-day hospital stay ranging from US\$30 to \$80.

At the end of the assessment, six sites were identified as future ProVIC pediatric care sites, three in Katanga (HGR Kenya, HGR Panda, and HGR Kasumbalesa), two in Kinshasa (Kingasani Maternity and CH Kikimi), and one in Kisangani (CSR Mokili). The managing officers of these sites expressed their satisfaction with the ProVIC approach aimed at increasing its intervention package within the same site, which will decrease the number of patients lost to follow-up due to having to walk a distance of several kilometers to receive care, particularly pediatric ART.

The information from the baseline report was used to guide the writing of partner agreements, taking into account expected targets per site and per year.

Activity 2: Introduce necessary laboratory testing for PLWHA

CD4 count. CD4 counts were performed in Q3 for PLWHA identified in the program, including pregnant women, their male partners, and other PLWHA attending the PMTCT

sites. The PIMA™ equipment for CD4 analysis is located in central sites, and peripheral sites refer samples for analysis.³

Other exams. Other tests performed prior to treatment initiation, such as hemoglobin, hepatic, and renal tests, are not reported here because the facilities which reported for this quarter did not receive funding to perform these analyses.

Activity 3: Ensure treatment for clinically eligible PLWHA

After performing clinical staging and CD4 count, eligible PLWHA were identified and initiated on first-line treatment (zidovudine+lamivudine+nevirapine). The nevirapine was replaced by efavirenz for patients receiving TB treatment. Two exposed children who tested HIV positive by DNA polymerase chain reaction were also initiated on ART. No major side effects or drug intolerances requiring hospitalization were noted.

Activity 4: Offer a continuum of care to PLWHA

To prevent the occurrence of opportunistic infections, cotrimoxazole prophylaxis was routinely provided to all PLWHA in Q3. To investigate major opportunistic infections, particularly TB, providers used the screening tool containing key questions regarding symptoms, notably persisting fever, cough lasting more than two weeks, wasting, and night sweats. Positive patients were asked to perform the rest of the analyses at their own charge, particularly hematology, sputum, and even pulmonary x-ray. HIV-positive patients testing positive for TB were initiated on TB treatment before ART, in accordance with the DRC’s current national protocol for TB/HIV co-infection. Patients with STIs were treated following the syndromic approach, as recommended by the PNLS.

Challenges during the reporting period and proposed solutions

Challenges	Proposed solutions
Some peripheral sites are located far from their central site. This increases results turnaround time, to the point of risking postponing the initiation of ART in some sites.	Equip peripheral sites located far from central sites with PIMA™ Analysers for CD4 count analysis.
As hemoglobin meters are not yet operational in all sites, ARV treatment with zidovudine remains a problem, fearing hematopoiesis side effects in pregnant women who already suffer from anemia.	ProVIC is procuring hemoglobin meters through SCMS and delivery is expected in late 2013. ProVIC has included funding for a minimum number of hemoglobin meters in its realigned budget and will procure after the budget has been approved.
National data collection tools for ART are not available in all sites.	Keep advocating at the PNLS level to make data collection tools available.
Some sites lack pediatric ARVs.	Work with PMTCT sites to place orders for ARVs as soon as treatment-eligible cases are identified.

³ Data, while available, are undervalued, as only Kinshasa has collected CD4 data for PLWHA other than pregnant women.

Activities planned for the next quarter for Intermediate Result 2

Sub-IR 2.1 <i>Care and support for PLWHA strengthened</i>	Sub-IR 2.2 <i>Care and support for OVC strengthened</i>	Sub IR 2.3 <i>HIV treatment in target areas improved</i>
Audit of PLWHA/OVC medico-social files in preparation for transfer to government stakeholders.	Finish requalification of OVC (data collection and service identification).	Provide CD4 count and other laboratory analysis if needed for PLWHA identified in Q4.
Continue to set-up PMTCT-focused SHGs led by mentor mothers & continue to promote linkages with community-SHGs.	Supervise the implementation of the CARITAS contract for educational support and vocational training for 5,850 OVC.	Provide highly active antiretroviral therapy for eligible PLWHA.
	Ensure the embedding of positive prevention into C2C groups.	
	Ensure issues of child registration are raised and addressed in the Mentor Mother groups.	

Intermediate Result 3: Strengthening of health systems supported

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

In Q3, ProVIC focused on ensuring a continuum of care to HIV-positive pregnant women and their families in the selected health zones and working across and within the other project components in order to promote integration under the new strategic focus.

Activity 1: Strengthen the referral and counter-referral systems

ProVIC continued to support the implementation of referral and counter-referral systems. Data collected from the datacards showed an improvement in the number of people who tested positive being successfully referred to additional services, such as CD4 testing, treatment, and social support, therefore ensuring the continuum of care.

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

ProVIC regional coordination in Bas-Congo has conducted one joint supervision visit with provincial partners. To ensure follow-up of activities in Sud Kivu, 22 monitoring meetings were organized in five supported health zones.

Activity 3: Support leadership-building activities within programs

As described in Sub-IR 1.2, Activity 2, ProVIC provided financial and technical support to the PNLS to organize a review meeting with partners to finalize the PITC training module. ProVIC technical staff contributed to different workshop sessions to produce the final PITC module.

Activity 4: Support trainings on the integrated package of HIV services organized around PMTCT in Katanga, Orientale, and Kinshasa

ProVIC worked closely with the PNLs to define and finalize the integrated training modules, the necessary first step in scaling up to new sites with the integrated vision of the Strategic Pivot and the PMTCT Platform. These modules are now a legacy which can be used by the PNLs and other partners going forward, constituting strengthening of the health system.

Data have been recorded for most of the trainings completed by ProVIC to date. In Q3 in Sud Kivu, 29 service providers from CS Cidasa and CS Malkia benefited from training in the new PMTCT protocol. Data regarding integrated PMTCT training conducted in Q3 in all project-supported provinces are represented in the table below.

Table 9. Number of trained PMTCT service providers in each province.

Site	Total
Boma/Bas-Congo	57
Kolwezi/Katanga	60
Likasi/Katanga	97
Lubumbashi/Katanga	110
Total	324

Activity 5: Support commodity management in the health zones

This is a new activity under the Strategic Pivot and will be addressed in Q4.

Activity 6: Reproduce and disseminate tools, manuals, and policy documents associated with ProVIC's interventions

Effective referrals and documentation of referrals remain a considerable challenge. ProVIC continues to make this a priority in its supportive supervision. We noticed in Kisangani that regular contact between the facilities has improved this link between the services, and as a result has increased the efficiency of the tracking system to ensure that clients have received services. Through collaborative agreements, supported health zones have received funding to organize monthly monitoring meetings in order to evaluate the system and to analyze examples of success and areas for improvement.

A range of materials, including training materials, was reproduced and distributed to health facilities in Q3, as shown in the following table.

Table 10. Documents and forms distributed in Q3.

Type of document	Number of copies
Prenatal consultation register	100
Mother-child follow-up register	100
Delivery room register	100
CPON register	100
Family members register	100
CPN form	2,000
Integrated HIV form	88
Integrated peer educator training module	88
Integrated service provider GBV training module	88

Activity 7: Support integrated supervision at the health zone level

In April, ProVIC supported a joint supervision visit at the provincial level with the PNLS to the PMTCT sites in all supported health zones in Kisangani. In Bas-Congo, the project organized one joint supervision visit with provincial partners. In Sud Kivu, a joint supervision visit, with the PNMLS, PNLS, and *Division des Affaires Sociales*, was conducted in Uvira, Bagira, and Ibanda Health Zones. The project team has also supervised visits to Aludrofe, Acosyf, Fondation Femme Plus, HGR Bagira, and CS Cidasa and CS Malkia.

Challenges during the reporting period and proposed solutions

Challenges	Proposed solutions
Follow-up training for service providers not in place.	Develop collaborative agreements with health zones in order to define follow-up activities and systems for service providers.
No specific indicator to track clients through the referral system in supported health zones.	Work with the M&E team to develop appropriate indicators to track referrals.

Sub-IR 3.2: Capacity of NGO partners improved

Activities and achievements

Activity 1: Strengthen the organizational capacity of partner NGOs

In response to the pivot, the focus in Q3 was on changes in relationships with and support to NGO partners. Activities concentrated on working with Fondation Femme Plus, *Réseau National des Organisations d'Assise Communautaire*, the Society for Women and AIDS in Africa, PSSP, *Organisation Non Gouvernementale Laïque à Vocation Socio-économique du Congo*, and World Production to finalize their administrative and financial manuals, as well as their strategic plans.

Challenges during the reporting period and proposed solutions

Challenges	Proposed solutions
Need to keep NGOs motivated in the context of strategic pivot	Keep emphasizing the need for linkages between community and health facilities and key role that NGOs can play in this.

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

Activities and achievements

In Q3, the M&E team focused on making substantial updates to ProVIC's data collection (and reporting) system in response to the Strategic Pivot. This included consultations with USAID, PEPFAR, the DRC government, local partners, and the project's technical and M&E specialists; updating ProVIC's online M&E database system, with short-term technical assistance from the project's database consultant; and training M&E focal points from both old and new PMTCT sites on the new, post-pivot datacards.

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

To ensure a strong, common understanding of additional project reporting requirements due to the Strategic Pivot, ProVIC's national M&E officer convened a one-week M&E system update workshop in Kinshasa in May, which included the project's entire M&E team. The long-term database consultant from Vera Solutions led an intensive, two-day session at the end of the week, focused on strengthening the capacity of ProVIC's national technical specialists, their assistants, and the entire M&E team to harness data from the online system to perform more rigorous data analysis.

Activity 2: Provide technical assistance for PNMLS and PNLS M&E activities at the national and provincial levels

ProVIC was very active in Q3 in sharing project data with government partners and contributing to increased understanding of the DRC's HIV/AIDS epidemic. Joint data validation discussions at both the national and provincial levels notably reflected a strong, common interest in the project's data on key populations (e.g., CSWs and MSM), for whom critical information gaps in HIV prevalence data persist. Highlights included:

- At the national level, ProVIC's national M&E officer participated in a two-day workshop on the country's epidemiological profile. During this workshop, organized by the PNMLS and held at the PNLS offices, ProVIC presented a wealth of HIV programming data from its database. Particular attention was dedicated to discussing data on key populations.
- ProVIC's Bas-Congo M&E officer participated in a meeting of the *Cadre de Concertation Multisectoriel de Lutte contre le SIDA* (Framework for Multisectoral Cooperation against HIV/AIDS), organized by the PNMLS provincial bureau with ProVIC's financial support. During the meeting, held at the World Health Organization's offices, the M&E officer presented ProVIC's second-quarter M&E project data, focusing on MSM-related data at the request of the PNMLS. ProVIC's MSM-targeted activities in Bas-Congo were recognized as both unprecedented and innovative by the provincial DRC government, which plans to publish a quarterly bulletin to share these data.
- In Kisangani, ProVIC's M&E officer participated in an HIV/AIDS Task Force meeting convened by the PNMLS. This meeting served to jointly validate the project's first-quarter data. As with the above-mentioned meetings, participants were especially interested in ProVIC's data on key populations.

Activity 3: Build implementing partners' M&E capacity

Upon completing our rigorous, project-wide exercise to update datacards to address additional, post-pivot reporting requirements, the ProVIC team quickly organized local partner trainings to roll out these updated data collection tools. In Q3, ProVIC organized datacard debriefings with M&E focal points from *existing* local partner organizations including 15 participants in Kinshasa, 33 participants in Katanga, and 17 participants in Sud Kivu.

For *new* (post-pivot) PMTCT sites, ProVIC's regional M&E officers trained M&E focal points in Katanga (21 people in Lubumbashi, 25 in Likasi, and 21 in Kolwezi), Orientale (47 people in Kisangani and 27 in Bunia), and Bas-Congo (12 people). M&E focal points from new PMTCT sites in Kinshasa will receive this training at the beginning of the fourth quarter.

Activity 4: Improve functionality of the M&E database to respond to USAID’s Strategic Pivot

As noted under Activity 1 above, ProVIC’s longstanding, international database consultant traveled to Kinshasa in May to provide short-term technical assistance to ProVIC’s M&E team. This support focused on the health management information system dimensions of updating ProVIC’s M&E system post pivot—especially to ensure that the online system will be properly configured to integrate the new datacards in a way that can still map to project data entered into the online system using the project’s old datacards.

Upon returning to their respective provinces, ProVIC’s regional M&E officers then, in turn, provided datacard update debriefings to their provincial-level technical staff.

Activity 5: Improve implementing partners’ capacity to conduct quality improvement and provide high-quality services

As part of ProVIC’s ongoing efforts to strengthen local partners’ capacity to deliver high-quality services, ProVIC’s M&E team conducted numerous data quality audits (DQAs) in the third quarter. In Kinshasa, DQAs were conducted at three PMTCT sites: Kingasani Maternity Hospital Center, HGR Mbakana, and Binza Maternity. While improvements in data quality were observed through these DQAs, under-reporting was noted at Kingasani, for example, due to data transcription errors and the failure of providers of care services to perform quality control reviews of entered data. In Bas-Congo, DQAs were conducted at HGR Boma, CSR Kalamu, and CSR Vulumba. While improvements in data quality were similarly observed among these sites, counting and transcription errors, as well as poor records management, were flagged as areas for continued improvement. In Orientale, four ProVIC-supported PMTCT sites (CSR Mokili, CS St. Camille, CS Neema, and CS Muungano) received trainings on quality assurance/quality improvement, and activities were then launched in these sites—expanding ProVIC’s successful quality assurance and improvement activities beyond the project’s initial pilot PMTCT sites in Kinshasa.

In addition to these ongoing activities, ProVIC’s M&E team continued to build local partners’ capacity for quality improvement by participating in health zone data validation meetings, and by closely monitoring and providing hands-on support to partners as they began completing their new, post-pivot datacards.

Challenges during the reporting period and proposed solutions

Challenges	Proposed solutions
Reporting on new referral and counter-referral indicators (for HIV continuum of care services), and on new treatment indicators.	Update ProVIC’s M&E system to account for these additional reporting requirements due to the Strategic Pivot (completed).
Bandwidth challenges among ProVIC’s M&E team to monitor data quality for all project activities, and among all local implementing partners, due to the ever-increasing number of implementing partners, increasing reporting requirements due to the Strategic Pivot, and sometimes long geographic distances to travel to sites.	Engage technical leads from each technical project component in monitoring data quality at the local implementing partner/site level; promote and assign ProVIC’s deputy national M&E officer (formerly assigned only to Sud Kivu) to Katanga as well, to help ensure strong M&E coverage to both ProVIC and <i>Projet SIDA Fungurume</i> (completed).

Activities planned for the next quarter 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 partners improved</i>	Sub-IR 3.3 <i>Strategic information systems at the community and facility levels strengthened</i>
Support health zone staff in their leadership and supervisory roles	Continue working with NGO partners to finalize key organizational documents and implement sound practices.	Conduct DQA in Kisangani.

QUARTER 3 PROGRAM MANAGEMENT UPDATE

Four key issues in Q3 affected project operations:

1. Six-week evaluation of ProVIC by four external auditors in May and June.
2. USAID's financial review of the project in April.
3. Security issues in the eastern region of the DRC.
4. PATH's internal audit of ProVIC in May.

USAID evaluation

ProVIC hosted an evaluation team that examined questions regarding ProVIC's PMTCT program and champion communities, among other implementation issues. While it was a very useful exercise which will inform future programming, the evaluation was very broad in scope and the team had allocated a relatively short time to carry out its work. Travel to provincial sites was also included and ultimately, the evaluation team required intensive support from ProVIC management and technical officers.

USAID financial review

USAID conducted a financial review of ProVIC in April, which focused on following up the recommendation made in 2012. Although the ProVIC management team was debriefed at the end of the review, PATH has not yet received any formal written follow-up to this review.

Security issues

In Kisangani, ProVIC was falsely implicated in a traffic accident which sadly killed a female student. ProVIC's offices were threatened and ProVIC expended considerable energy in coordination with provincial police and other authorities to ensure that accurate information was shared with the public that ProVIC vehicles (of which there are none in Kisangani) were not involved.

Violence and instability continued around Goma, linked to the rebel movement M23. ProVIC's operations in Sud Kivu were not affected, but ProVIC continues to monitor the situation closely.

ProVIC internal audit

PATH conducted an internal audit of ProVIC in May.

Staffing changes:

- Bobwa Wanya Rodrigue started in April as Prevention Specialist in the Matadi office.
- Alexandre Kabanga left the HIV/AIDS Alliance as Care and Support Specialist to join Chemonics as Regional Coordinator for their Bukavu office. Mr. Kabanga had served in the interim after the former Regional Coordinator, Dr. Didier Kamerhe, was forced to leave Bukavu for security reasons in late 2012.
- Mbayi Katungulu started in May as Internal Controller.
- Hippolyte Nkoy Mwakanzal, Health Systems Strengthening Specialist, departed to join Chemonics as Deputy Regional Coordinator for their Kinshasa office.

- Paul Ngoie Mwilambwe started in April as Assistant Grant Manager in the Katanga office.
- Venant Cikobe Zihahirwa was promoted to Deputy M&E Officer and moved from Bukavu to Katanga.
- Didier Kabwe started as PMTCT Specialist for the Katanga office.
- Antoine Masekwe started in April as Logistics Assistant in the Katanga office; he was later recruited by SCMS and left PATH in July.
- Tryphon Mbadinga, an accountant in the Kinshasa office, left the project in May.
- Jeannette Kanyembo left the project in May; she had cleaned the Katanga office.
- Olivier Kabeya, Information Technology Manager, left the project in June.

QUARTER 3 ENVIRONMENTAL MONITORING AND MITIGATION ACTIVITIES

Activity	Potential negative environmental consequences	Status report
HTC	HTC generates biohazardous health care waste such as syringes and other sharps, which if not disposed of properly are a health risk for those who come in contact with them. HTC also involves blood drawing, storage, and disposal, which may be hazardous if not performed properly.	<p>All HTC 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>ProVIC has shared all relevant normative documents, including national policy, job aids, and reporting templates and guidelines, for environmental protection.</p>
PMTCT	PMTCT includes HTC and therefore the risks mentioned above. In addition, the labor and delivery process often requires the use of syringes, needles, and other sharps, as well as methods to remove blood and other bodily fluids and sanitize 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. ProVIC also held integrated PMTCT trainings for 324 health service providers and community agents, which included training in biomedical waste management and injection safety. ProVIC continued to regularly monitor biomedical waste management at health facilities during supervision visits in the third quarter.</p> <p>All PMTCT sites have adequate equipment to dispose of waste safely</p>

Activity	Potential negative environmental consequences	Status report
		(sharps disposal containers, waste pits, and facilities for incineration or other safe disposal). ProVIC supplied new PMTCT sites in Katanga with material and equipment, such as bleach, alcohol, gloves, and disposal containers, to ensure proper collection, handling, transportation, and elimination of biomedical waste.
Palliative care	Palliative care for PLWHA includes the use of hazardous sharps and exposure to bodily fluids which may be infectious.	Community health workers have received training and appropriate supplies for home visits.