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Cover Photo: A nurse uses a newly-installed hand washing post in the health zone of Lemera in Sud Kivu.

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ACRONYMS

ACF	Action Against Hunger
AMTSL	Active Management of Third Stage Labor
APOC	African Program for Onchocerciasis Control
ARV	Antiretroviral
AS	Health Area
AXxes	Integrated Health Services Project in DRC
BCC	Behavior Change Communication
BCZ	Bureaux centraux des zones de santé (health zone central offices)
CBD	community-based distribution or community-based distributor
CDMT	Medium-term expenditure framework
c-IMCI	Community-based Integrated Management of Childhood Illness
CLTS	Community-led Total Sanitation
CODESA	Comité de Développement Sanitaire (health development committee)
CPA	Complementary Package of Activities
CDR	Regional Distribution Center
CPR	Contraceptive Prevalence Rate
CYP	Couple Years of Protection
DPT3	Diphtheria, Polio, Tetanus
DPS	Division Provinciale de la Santé (provincial health division)
DQS	Data Quality Self-Assessment
DRC	Democratic Republic of the Congo
ECZ	Equipe Cadres de Zone (health zone management team)
EMMP	Environmental Monitoring and Mitigation Plan
EPI	Expanded Program on Immunization
FBO	faith-based organization
FFSDP	Fully Functional Service Delivery Point (see FOSACOF below)
FOSACOF	Formation Sanitaire Complètement Fonctionnelle (Fully functional service delivery point)
FP	Family Planning
GRH	General Referral Hospital
HA	Health Area
HBB	Helping Babies Breathe
HC	Health Center
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HZ	Health Zone
IHP	Integrated Health Project
IMaD	Improving Malaria Diagnostics
IMCI	Integrated Management of Childhood Illness
IPS	Inspection Provinciale de la Santé (Provincial Health Inspection)
IPT	Intermittent Preventive Treatment (of malaria) in pregnancy
IRC	International Rescue Committee
IT	Infirmier Titulaire (head nurse)
ITN	Insecticide-treated nets
KAPs	knowledge, attitudes, and practices
KMC	Kangaroo Mother Care

LDP	Leadership Development Program
LLIN	Long-lasting insecticide-treated net
LMS	Leadership, Management, and Sustainability Program
MOH	Ministry of Health
MNCH	Maternal, Newborn and Child health
MIP	Provincial Medical Inspector
MLM	Mid-level management
MPA	Minimum Package of Activities
MSH	Management Sciences for Health
NGO	Non-governmental Organization
NTD	Neglected Tropical Diseases
OSC	Overseas Strategic Consulting, Ltd.
PBF	Performance-based Financing
PEP	Poste d'eau potable
PEPFAR	President's Emergency Plan for AIDS Relief
PEV	Programme Elargi de Vaccination (expanded immunization plan)
PHAST	Participatory hygiene and sanitation transformation
PMP	Performance Monitoring Plan
PMTCT	Prevention of mother-to-child transmission
PNDS	Plan National de Développement Sanitaire (National health development plan)
PNLS	National AIDS Program
PNSR	National Reproductive Health Program
PPDS	Provincial Health Development Plan
RDC	Regional Distribution Center
RDT	Rapid diagnostic tests
RECO	Relais Communautaires (community outreach workers)
RH	Reproductive Health
RHC	Referral Health Center
RPR	Rapid plasma reagin test for syphilis
SARAR	Self-esteem, associative strengths, resourcefulness, action planning, and responsibility
SNIS	National health information system
SPS	Strengthening Pharmaceutical Systems Project
SMS	Short Message Service
TB	Tuberculosis
TBA	Traditional Birth Attendant
TFR	Training for Results Framework
USAID	United States Agency for International Development
USG	United States Government
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WASH	Water/Sanitation/Hygiene
WHO	World Health Organization

EXECUTIVE SUMMARY

This report covers the fourth quarter reporting period, from July to September 2011, and serves as the annual status report of the first year (hereafter referred to as PY1) of the five-year, USAID-funded Integrated Health Project (IHP) in the Democratic Republic of Congo (DRC). The DRC-IHP supports the National Health Development Program of the DRC. The project's two components—Component 1, "Services," and component 2, "Other Health Systems"—are designed to create better conditions for, and increase the availability and use of, high-impact health services, products, and practices in 80 target health zones in four provinces of DRC (Kasaï Occidental, Kasaï Oriental, Katanga and Sud Kivu).

The project's goal, purpose and objective is to improve the enabling environment for, and increase the availability and use of, high-impact services, products, and practices for family planning; maternal, newborn, and child health; nutrition, malaria, and tuberculosis; neglected tropical diseases; HIV; and water/sanitation/hygiene in the target health zones.

Component 1 supports the first strategic focus of the DRC's national health plan: health zone strengthening. Activities under Component 1 strengthen health zones' capacity to deliver services by addressing both the supply and demand sides of services. Under Component 1, there are three Intermediate Results (IRs):

- IR 1: Access to and availability of Minimum Package of Activities/Complementary Package of Activities plus (MPA/CPA-plus) services in target health zones increased
- IR 2: Quality of MPA/CPA-plus services in target health zones increased
- IR 3: Knowledge, attitudes, and practices (KAP) to support health-seeking behaviors increased in target health zones

Component 2 corresponds to the plan's second strategic pillar, support for health zone strengthening in six priority areas: human resource development; pharmaceutical management; health finance; construction/rehabilitation of infrastructure; equipment and new technologies; and improved health system management. Activities under Component 2 create an enabling environment for strong health zones, with particular emphasis on leadership and governance and the provision of resources. The DRC-IHP's fourth Intermediary Result is found under component 2:

- IR 4 : Health sector leadership and governance in target provinces improved

Implementing Partners: The implementing partners are Management Sciences for Health, the International Rescue Committee and Overseas Strategic Consulting, Ltd. (hereafter referred to, respectively, as MSH, the IRC, and OSC, Ltd.).

KEY MILESTONES YEAR 1

Component 1: Health Services

- IHP carried out numerous assessments to determine the current situation in health zones in terms of equipment, medicines, availability of MPA/CPA-plus, and to map the interventions of actors also working in the health field. In the final quarter of PY 1, this assessment included actors working on gender-based violence issues, as well HIV/AIDS treatment, referral, and advice in health zones and community care sites.

- The project planned for, provided appropriate training, and implemented WASH activities throughout the year. In the fourth quarter, a consultant trained IHP and relevant health zone and district staff on key WASH concepts to be integrated into the IHP WASH strategy; these included Community-Led Total Sanitation (CLTS) and Participatory Hygiene and Sanitation Transformation (PHAST). IHP developed training modules for community health workers and community water associations. IHP rehabilitated water sources, distributed hand washing stations and drinking-water containers, sensitized communities on the use of latrines, and delivered materials, leading to the construction of family latrines in communities, as well as in selected health facilities.

- IHP distributed long-lasting insecticide-treated mosquito nets from the Presidential Malaria Initiative (PMI). By the close of PY1, IHP distributed a total of 61,234 nets in Bukavu, 25,370 in Uvira, and 16,938 in Kolwezi to the target groups of pregnant women. IHP will continue to monitor project indicators to evaluate the impact of these distributions into PY2. In addition, IHP distributed family planning commodities and blood transfusion security supplies to health zones under all the coordination offices in all four USAID-supported provinces.

- IHP actively collected and analyzed health information in target health zones, participated in supervisory visits to health zones with members of the health zone management teams, and participated in monitoring meetings at health zone and health area levels. IHP provided fuel to health zones to facilitate supervisory visits, and towards the end of PY1 shipments of medicines arrived and were delivered to the central warehouses for distribution to health zones.

- IHP conducted numerous training sessions for provincial, health district, and health zone management team representatives on a variety of topics in PY1. These training sessions included the Mid-Level Management training; training of trainers on Fully-Functional Service Delivery Point (FOSACOF) methodology, followed by training to service providers; Leadership Development Program training; training of trainers on the use of clinical flow charts; training on the kangaroo method of care for underweight newborns; training of members of blood donation associations; as well as the WASH training sessions mentioned above.

- IHP achieved the following in behavior change communication (BCC) and community outreach:
  - Trained 21 IHP staff and MOH representatives in BCC and ETL techniques and methodologies and developed BCC and ETL training and reference materials
  - Existing KAP data for IHP health domains target zones reviewed
  - Developed overarching draft IHP BCC Strategy for PY2-5 through consultative process with key MOH programs, Directions and strategic partners
  - Developed IHP/C-Change joint action plan for the “3+1 Campaign” against malaria

- Concluded SMS pre-pilot in 2 health zones, including an assessment of mobile phone-based intervention opportunities
- Completed rapid assessment of health communications capacity in 4 IHP provinces

Component 2: Health Systems Strengthening

- At the close of project year 1, in collaboration with provincial MOH authorities, IHP succeeded in assessing and revitalizing 904 out of 1,428 CODESAs (63% of all CODESAs). While all field offices are on track for this activity, the field office in Mwene Ditu merits specific recognition, having succeeded in assessing and revitalizing all 194 CODESAs in its coordination area (100% completion rate).

- In conjunction with the FOSACOF training of trainers, IHP distributed manuals on MOH Health Zone Standards, the revised version of the MOH's Strategy for Reinforcement of the Health System, trainers guides on clinical flow charts, and the MOH list of essential generic medicines.

- IHP supported the promotion of International Breastfeeding Week in Walungu, Katana, and Minova health zones of Bukavu from August 3-13, 2011. IHP teams supported the health zones to conduct sensitization campaigns towards local leaders, the general community and women's associations.

Project Management:

- IHP completed and presented its baseline study. As documented in previous quarters, IHP submitted a full report documenting the baseline study conducted in April-May 2011. After a presentation and technical discussion with USAID, the report was approved. IHP disseminated the findings of the baseline by sharing the technical report with various stakeholders, including the MOH, at different levels and other partners in DRC.
- IHP supported the health zones, district and provincial authorities, participating in the Annual Operational Plan process and providing direct support to health zones pending the approval of the grants template by the USAID Agreements Officer.
- IHP ensured that the Kinshasa office and all coordination offices were functional and staffed, and all staff received appropriate administrative and technical orientation; when challenges arose, IHP worked with USAID and the IHP partners to resolve them.
- To overcome challenges related to signature of support agreements with target health zones, MSH provided in-kind support to all health zones in all four provinces.

I. PROJECT PERFORMANCE: ACTIVITIES AND ACHIEVEMENTS

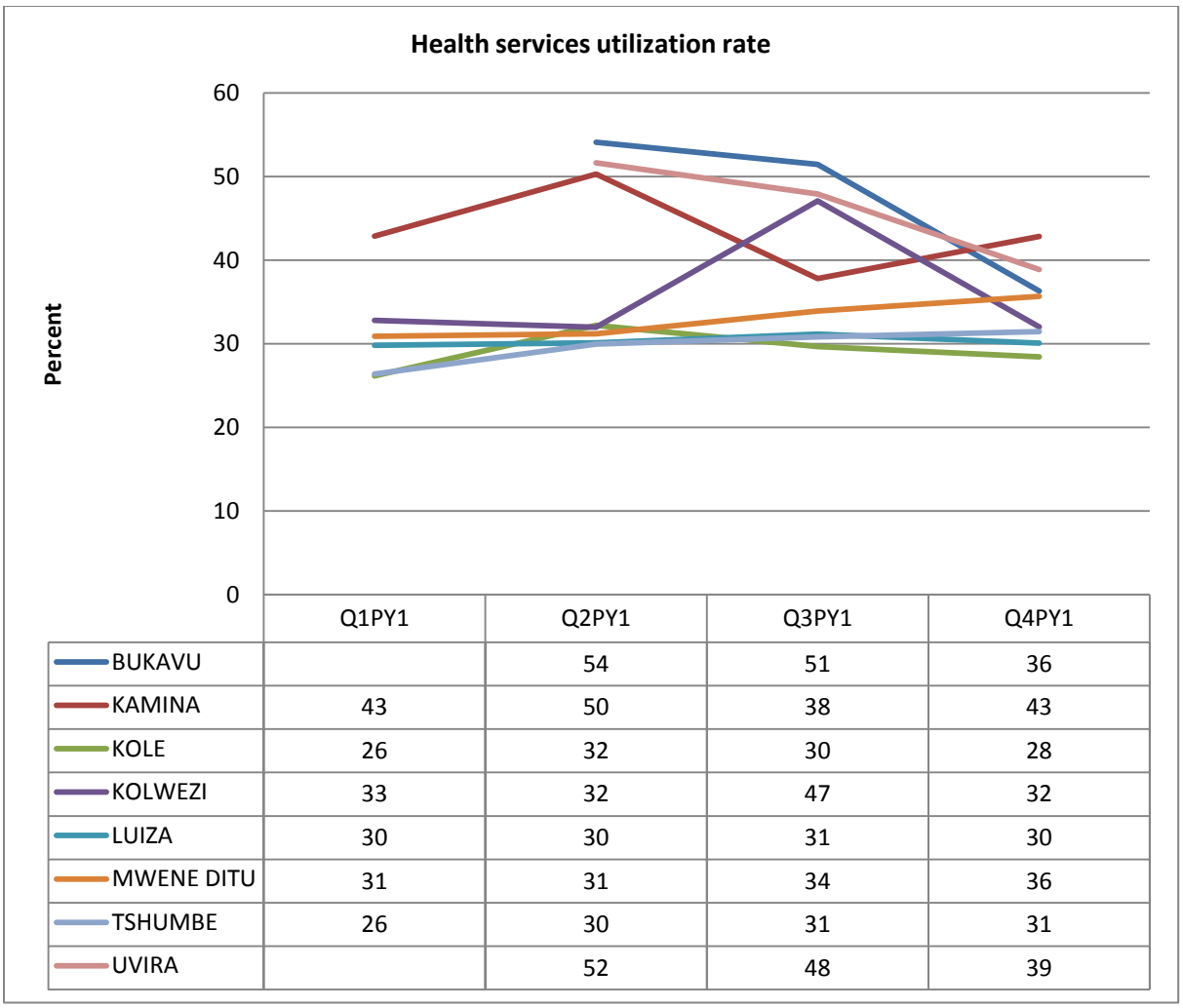
I.1 COMPONENT 1: HEALTH SERVICES

Intermediate Result 1: Access to and availability of Minimum Package of Activities/Complementary Package of Activities plus (MPA/CPA-plus) services in targeted health zones increased

The service utilization rates in Figure 1 show a mixed trend of curative services in the IHP target health zones, with Mwene Ditu and Tshumbe reporting an increasing trend during PY1. While the trend is unstable in Kamina and Kolwezi, curative services in Luiza and Kole are somewhat stable around 30%.

Bukavu and Uvira are still facing challenges in the provision of curative services with a decreasing trend due to a number of factors, including stock outs of essential medicines and vaccines, weak community outreach through low activities from community health workers, quality of data, and security issues. While IHP has used a number of approaches to strengthen the provision of curative services during PY1, including support for immunization campaigns, transportation and other logistical support, quarterly review meetings and follow-up visits, the project will continue to expand these approaches and learn from those coordination offices showing an upward trend in curative services.

Figure 1: Utilization rate of health services in IHP-targeted areas by quarter and by coordination office



	Q1PY1	Q2PY1	Q3PY1	Q4PY1
BUKAVU		54	51	36
KAMINA	43	50	38	43
KOLE	26	32	30	28
KOLWEZI	33	32	47	32
LUIZA	30	30	31	30
MWENE DITU	31	31	34	36
TSHUMBE	26	30	31	31
UVIRA		52	48	39

IR 1.1 Facility-based health care services and products (zonal hospitals and health centers) in target health zones increased

Activity 1: Conduct MPA/CPA-plus capacity and needs assessment of health centers and GRH in target health zones

The Kolwezi office finalized the MPA/CPA-plus capacity and needs assessment at the beginning of the quarter in its eight health zones in collaboration with Kolwezi health district and the ECZS of each health zone. This completes the MPA/CPA-plus assessments for Year 1 (other assessment results have been

reported in previous reporting periods). The assessment included an inventory of materials left from the AXxes project, as well as the level of integration of MPA/CPA-plus in the health facilities. Among other things, the assessment revealed that all of the motorbikes received from the AXxes project are not working, making supervisory visits difficult. The IHP team noted which repairs were necessary and these will be carried out in the coming quarter. The assessment also revealed that none of the health facilities visited is providing a complete MPA/CPA-plus package. Based on this information, the team will prepare an integration plan early in the coming project year to ensure the completeness of the packages.

The Uvira office finalized its assessment of primary health care facilities in 104 health areas in all five health zones under its coordination. The information was collected directly in 54 of these facilities and in the remaining 50 the information was collected indirectly through the Zonal Health Offices (BCZS) due to security restrictions caused by the presence of armed groups in the health zones of Haut Plateaux, Lemera and Nundu. The assessment's preliminary results showed that Lemera includes a higher number of health areas (24) than the maximum 21 recommended by the health district. The IHP team has begun to address this, asking the ECZ to update its coverage plan and integrate it into the operational action plan for 2012, and submit it for validation by the Administrative Council and the MIP. The assessment also allowed IHP teams to finalize the mapping exercise, noting actors and their interventions by health area and health zone. Finally, it also provided the team with the inventories of basic equipment available at all levels, which revealed that most motorbikes used for supervision are not working, but all computer equipment remains functional.

The Bukavu office also finalized the assessment of its health zones in August, following a period of insecurity that had prevented access to the Mulungu health zone last quarter. In addition, the gender specialist's arrival enabled the Bukavu office to assess and map current interventions in the field of gender-based violence. The results of this assessment are available from the IHP Kinshasa office.

The IHP technical team based in Kinshasa carried out several missions in Sud Kivu to improve the quality and completeness of the package of activities. These included a joint mission of a national Prevention of Mother to Child Transmission (PMTCT)/National AIDS Program (PNLS) expert and the head of the HIV/Tuberculosis team of IHP, which focused on PMTCT and Health Center for the Diagnosis and Treatment of Tuberculosis (CSDT) activities, and a mission to visit community case management sites.

The visits highlighted the following issues, which will be used to inform IHP's strategy on HIV/AIDS:

- Weak leadership and coordination by the National AIDS Program, with consequently no integrated AIDS strategy across organizations working in the field
- Insufficient availability of data collection tools at PMTCT sites
- Infrequent supervision of HIV/AIDS activities by the ECZS or the National AIDS Program, likely due to a lack of supervision costs and the fact that many sites have stopped providing PMTCT services due to lack of materials
- Lack of suitable infrastructure for quality counseling in most sites (creating problems of confidentiality)
- Low knowledge of PMTCT, means of HIV transmission, and prevention methods.

Activity 2: Prioritize and implement infrastructure improvements to target health zone facilities
In the fourth quarter of PY1, the Kolwezi, Bukavu, and Uvira offices started the process of identifying health care facilities to be rehabilitated in collaboration with the health districts and health zones. The facilities were selected based on security and geographical access, after considering the access

difficulties in Sud Kivu. Ten health facilities were selected in five health zones in Bukavu, four in four health zones in Uvira, and eight in eight health zones in Kolwezi, where the verification of these selections is ongoing. Those selected are shown in Table 1. These potential renovations will be confirmed with the MOH during the 2012 planning process and aligned with the PY2 IHP budget.

Table 1: Health care centers selected for rehabilitation

Health zone	Health care centers selected for rehabilitation
Bukavu Coordination Office	
Bagira	Health centers Burhiba and Cigurhi
Ibanda	Health centers Muhungu and CECA 40 Nguba
Kadutu	Health center Camp Mweze CECA 40 and general reference hospital in Kataliko
Miti Murhesa	Health centers Bushumba and Mushunguri
Nyangezi	Health centers Kashenyi and Kalunga
Uvira Coordination Office	
Nundu	Lusenda and Swima
Lemera	Nyamutiri
Uvira	Kabimba
Kolwezi Coordination Office	
Bunkeya	Health center Kalwa
Dilala	Health center Dilenda
Fungurume	Health center Kando
Kanzenze	Reference health center in Walemba
Lualaba	Health center Lualaba Gare
Lubudi	Health center Lubudi
Manika	The general reference hospital in Mwangeji
Mutshatsha	Health center Maisha

Bukavu and Uvira launched a call for tenders for construction companies to carry out this work; construction will begin early in the coming quarter. The Bukavu, Uvira, and Kolwezi offices each began the recruitment process for an engineer who will be responsible for monitoring the rehabilitation.

Activity 3: Improve the supply of medications, commodities and products at facilities

IHP distributed family planning items to health zones in Kolwezi and limited supplies to Uvira throughout August and September (see Tables 2-3). Certain items distributed were from the previous AXxes project, notably oral contraceptives. The training of trainers (TOT) on insertion of intrauterine devices (IUD) is planned for early next quarter for Kolwezi and Kamina, where two technical staff from each IHP office will take part, in addition to district and provincial staff.

Table 2: Family planning items distributed in Kolwezi and Uvira during Q4

Province/ health zones	Family planning items distributed in Q4								
	Depo provera	**Microgynon**	**Ovrette**	**IUD**	**Jadelle**	**Male Condom**	**Female Condom**	**Microlut**	**Cycle beads**
KOLWEZI									
Bunkeya	800	0	0	5	0	0	0	40	0
Dilala	2400	100	800	14	20	7200	500	115	338
Fungurume	1600	0	0	6	0	7200	1500	50	500
Kanzenze	1200	80	224	14	11	7200	0	173	500
Lualaba	6400	240	700	40	14	28800	500	240	470

Lubudi	800	800	700	12	0	3000	498	82	294
Manika	3200	100	800	33	20	7200	500	262	500
Mutshatsha	1200	80	700	7	4	7200	0	50	300
Total	**17600**	**1400**	**3924**	**131**	**69**	**67800**	**3498**	**1012**	**2902**
UVIRA									
Hauts Plateaux	825	0	0	12	04	17000	381	60	250

DRC-IHP continued to supervise the distribution of long lasting insecticide-treated mosquito nets (LLIN) during this reporting period. While the PMI target beneficiaries are pregnant women, DRC-IHP supervisors noted in August 2011 that in Kolwezi, nets were being distributed to non-target groups in certain health zones. In Kanzeze, for example, the general reference hospital (GRH) was distributing nets to children under the age of five. The DRC-IHP team therefore sensitized health zones on the distribution criteria for these nets. In Bukavu, nets continue to be distributed in conjunction with preparation for the general distribution campaign scheduled for the next quarter. Due to security constraints in the Mulungu health zone, however, nets have yet to be distributed in this area.

Photo 1: Distribution of long lasting insecticide-treated mosquito nets to pregnant women in Manika

IHP also ensured the provision of blood-transfusion security items-- in particular blood bags and markers (HIV and Hep B)--in Kolwezi, Uvira, and Bukavu.

Table 3: Distribution of blood-transfusion security items in Kolwezi, Uvira, and Bukavu

Province/ health zones	Q4			
	HIV Marker	**Hep B Marker**	**Bags 250ml**	**Bags 450ml**
KOLWEZI				
Bunkeya	200	200	210	20
Dilala	400	300	150	0
Fungurume	300	300	150	0
Kanzenze	700	700	50	0
Lualaba	200	200	100	0
Lubudi	400	400	110	0
Manika	900	800	100	0
Mutshatsha	700	700	100	0
Total	**3800**	**3600**	**970**	**20**

UVIRA				
Nundu	0	0	550	500
Ruzizi	0	0	541	470
Uvira	0	0	800	600
Lemera	0	0	530	460
Hauts-Plateaux	0	0	230	210
Total	**0**	**0**	**2651**	**2440**
BUKAVU				
Kadutu	0	0	1386	834
Ibanda	0	0	1236	744
Bunyabkiri	0	0	1194	714
Miti-Murhesa	0	0	936	558
Minova	0	0	540	324
Kalonge	0	0	180	108
Katana	0	0	1494	900
Idjwi	0	0	1530	918
Kalehe	0	0	0	0
Bagira	0	0	138	84
Nyangezi	0	0	990	594
Walungu	0	0	486	288
Kaziba	0	0	336	204
Mulungu	0	0	450	270
Mwana	0	0	360	216
Mubumbano	0	0	360	216
Mwenga	0	0	228	132
Kitutu	0	0	474	282
Kamituga	0	0	4860	2916
Kaniola	0	0	180	108
Shabunda	0	0	1128	672
Lulingu	0	0	138	84
Kalole	0	0	450	270
Total	**0**	**0**	**20,523**	**12,306**

Since health zones do not have the means to transport their orders placed at the warehouse, the IHP coordination in Kolwezi ensured the transport of these orders.

Activity 4: Reinforce logistic and management systems for medicines, family planning commodities, LLITNs and consumable medical equipment

IHP completed procurement of essential medicines and medical supplies for PY1, and shipments of drugs began arriving in country in July 2011. IHP has progressively delivered these commodities to the eight CDRs that signed a contract with IHP during the last quarter to manage pharmaceutical under IHP

responsibility (see Appendix 4 for the list of products delivered to date). Since the procurement of medicines is planned for every year of the project, IHP will continuously review the systems in place for procurement, distribution, and tracking of pharmaceutical stocks to ensure that they function optimally to ensure availability of health commodities to health facilities in the four USAID-assisted provinces. To this end, IHP is working, with SPS support, to develop pharmaceutical management procedures using a very participatory process that captures input from provincial stakeholders (CDR managers, provincial pharmacists, and IHP and SPS representatives).

In PY1, the DRC-IHP completed its quantification exercises and prepared initial pharmaceutical orders as soon possible due to projected drug shortages secondary to inadequate inventory remaining from the prior recipient procurements. This situation led to an abbreviated quantification exercise with a very small window to validate the quantification. The quantification was based on data from a costing study which determined a fixed quantity of each drug/supply per health center; adjustments were later made when other factors (such as morbidity data) were considered.

For PY2, since most drugs for PY1 began arriving in August and September 2011, there again will be a paucity of consumption data from the CDRs. For the PY2 quantification, given the historical data available at the CDRs, once IHP completes the quantification the project will forward it to the CDRs for them to perform a quantification reasonableness test and report their recommendations to IHP for review and possible amendment to the quantification. Moreover, IHP plans to carry out a 24-month quantification to be reviewed and updated every 6 months. These procedures will be finalized and implemented in PY2. IHP has drafted a timeline to implement the quantification of PY2 pharmaceutical needs.

Activity 5: Improve the capacities of human resources to deliver MPA and CPA-plus packages
The Bukavu and Uvira offices rescheduled the training on the use of clinical flow charts until the next quarter because the publication of the tools revised by the Ministry of Health (MOH) was delayed. The Kolwezi office carried out a TOT at the end of the fourth quarter; IHP trained 42 staff from the health zone management teams, health district, and province as trainers who will subsequently train service-providers in health zones.

In addition, the Kolwezi office participated in a TOT on Kangaroo care, organized by the team in Kinshasa in July. A doctor and a nurse from the pediatrics department of the GRH in Dilala–selected because it has prior experience in this area–as well as one IHP staff member were trained, in order to establish a Kangaroo care unit to take care of underweight newborns in the health zone. In August, this doctor and nurse presented the method to representatives of all 8 ECZS, to ensure that they were capable of organizing this service in their respective hospitals and to supervise these activities after their own service providers are trained, which is planned for early on in year 2.

IR 1.2 Community-based health care services and products in target health zones increased

Activity 1: Integrate CODESAs into health zone strengthening activities
Details of the assessment of CODESA functionality can be found in IR3.2. The preliminary results indicate that the main challenge to integrate CODESAs into health zone strengthening activities is to train and ensure the collaboration of community outreach workers *(relais communautaires)* and CODESAs. The *relais communautaires* procedure is not yet well defined and discussions are underway on how to orient the IHP strategy to take into account these realities. In addition, in Bukavu, the DRC-IHP participated in

CODESA meetings to build their capacity in monitoring the use of mosquito nets by pregnant women at home.

Activity 2: Train, equip, and mobilize community distributors of family planning commodities
IHP ordered 1,267 bicycles for distribution to the CBD agents, which will arrive early in PY2. IHP supplied CBDs on a routine basis with family planning commodities.

Activity 3: Scale up community case management and treatment of childhood illnesses (e.g. malaria, diarrhea, and pneumonia)
IHP held preliminary briefings for the ECZ on the assessment of the community case management (CCM) sites. These briefings reinforced the goals, uses and roles of community care sites and trained ECZ staff on the assessment methodology. In the next quarter, the implementation of the scale-up plan for community case management and treatment of childhood illnesses will continue. IHP evaluated the functionality of community case management (CCM) sites in 49 target health zones, to collect the necessary data to analyze the activities being conducted at C-IMCI/CCM sites, in order to revitalize those activities. The specific objectives of the evaluation were as follows:

1. National level

- To update the community health care site database in relation to the 49 health zones.

2. Intermediate level

- To identify the people involved in the management of community health care site activities
- To identify a CCM site representative
- To provide the items necessary to create a database of CCM sites
- To advocate for the creation or revitalization of the child survival commission to strengthen CCM activities

3. Operational level

- To identify functional health care sites by health area and by health zone
- To determine the level of functionality of existing health care sites (number of new cases in the last six months, availability of inputs, and medications)
- To determine the contents of the intervention package (curative care, family planning, communication, EPI, etc.)
- To create a directory of existing and active health workers
- To create a directory of FP-trained sites and health workers
- To identify health worker motivation strategies
- To identify potential causes of site health workers discontinuing activities
- To identify the different supply circuits for medications and inputs for health care sites
- To determine the service cost recovery mechanism at sites

The methodology used is summarized into the following four phases:

1. *Development of data collection tools*: In conjunction with the C-IMCI coordination, IHP prepared six streamlined data collection frameworks for the following levels: provincial health offices; health districts; health zone central offices; health centers; CCM sites; and communities. IHP held a working meeting at the national level with the C-IMCI national coordinator for the adoption of these collection tools.

2. *Identification and briefing of national and provincial supervisors:* Eight managers from the National Program for the Fight against Acute Respiratory Infections (PNIRA) and from the National Program for the Fight against Diarrheal Disease (PNLMD) at the central level were briefed on supporting the four IHP provinces involved in this activity. The briefings took place in all four provinces.

3. *Data collection and transmission:* The eight national level managers collected the data at the provincial health division level, and the provincial level managers and members of the IHP team collected the district level data. Health zone managers (MCZ and AC) collaborated with nurses, health workers and community leaders to do the data collection.

4. *Data entry, analysis, production of results, preparation and distribution:* The data received from provinces and coordination offices was entered into the database and analyzed, and IHP prepared a report on the situation analysis. With the information now collected in one place, the DRC-IHP and the IMCI coordination areas now have a CCM site database in place.

While the full draft report of the IHP assessment of the functionality of the sites is not yet available, some preliminary findings are provided in the following paragraphs.

Four criteria were used to evaluate the functionality of CCM sites in the health zones targeted by IHP:

- Existence of CCM sites initially established with active health worker presence
- Monitoring and supervision of trainee health workers
- Availability of medication, materials and management tools
- Use of/user count at CCM sites

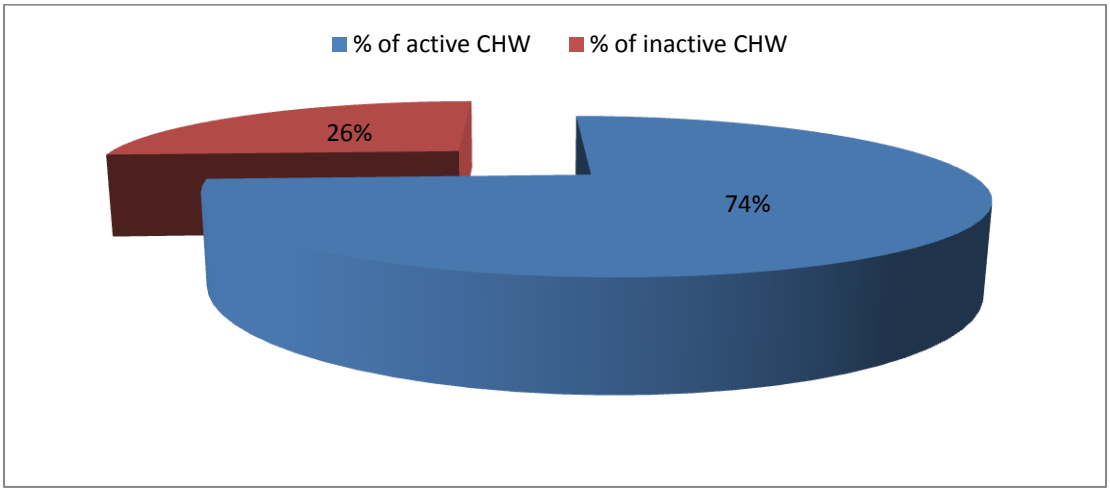
1. **The existence of CCM sites initially established with the presence of active health workers:** Table 4 shows that 345 CCM sites, i.e., 77.2% of planned sites, are currently in place in 45 of the targeted 49 health zones. Four health zones--Lwamba and Mukanga in Katanga, Minga in Kasaï Oriental, and Kaniola in Sud Kivu--have no continuing CCM sites. The 33 CCM sites planned for these four health zones were not established, even though the health workers had been trained; 69 other sites among those initially established no longer exist. Overall, 102 CCM sites do not exist in the target health zones.

Table 4: Distribution, by province, of existing and established CCM sites and the trained and active community health workers (CHW) in the health zones targeted by IHP

Provinces	No. of health zones with CHCS	No. of CCM sites initially established	No. of CCM sites currently existing	% of CCM site continuity	No. of CHW trained	No. of CHW currently active	% active CHW
Kasaï Occidental	5	61	55	90.2	110	92	83.6
Kasaï Oriental	12	153	121	79.1	271	200	73.8
Katanga	16	121	89	73.6	200	147	73.5
Sud Kivu	16	112	80	71.4	188	131	69.7
TOTAL	**49**	**447**	**345**	**77.2**	**769**	**564**	**74.1**

It is worth noting that of the 769 health service workers trained, 570, or 74%, are still active at the 345 sites; 119 (34.5%) of them work alone and 226 (65.5%) work in pairs at CCM sites.

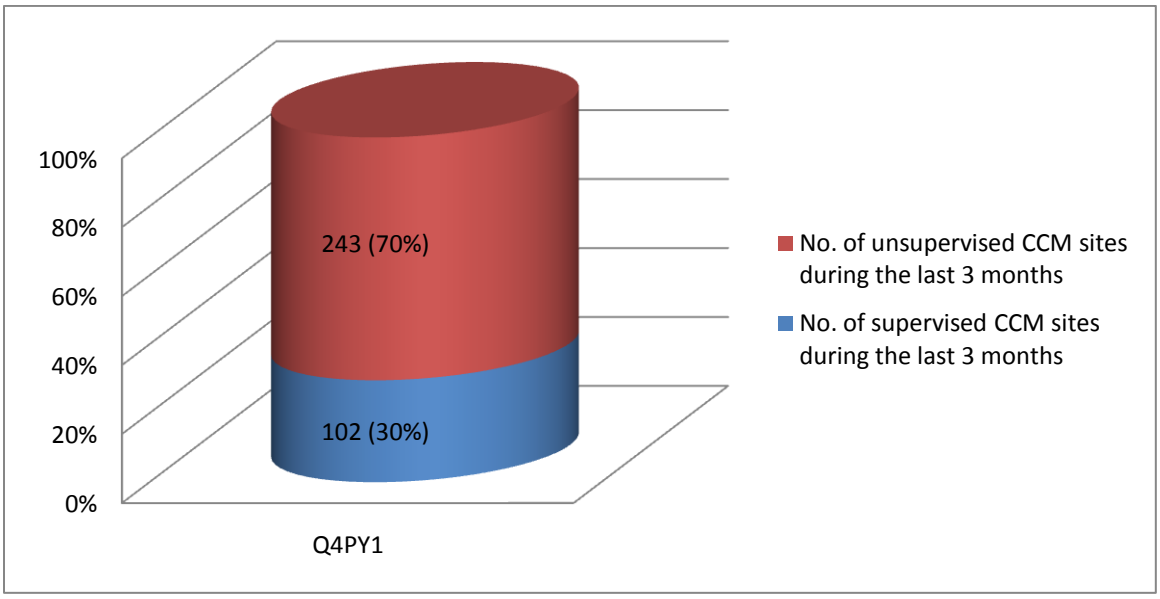
Figure 2: Loss rate of community health workers initially trained in the health zones targeted by IHP



As Figure 2 illustrates, roughly two years after they received initial training, the loss rate of trained community case management workers is estimated at one in four (26%). There are several reasons for this, including the following: insecurity; moving away from the village where the site is located; low morale due to shortages of medicines and supplies; marriage; and other reasons.

2. **Monitoring and supervision of trained and active community case management workers at sites:** Figure 3 illustrates that 102 of 345 CCM sites (29.5%) received at least one supervisory visit from a head nurse from the health area, in the three months preceding the situation analysis. About 70% of the sites (243) did not receive a visit from a head nurse.

Figure 3: Number of CCM sites that were supervised by at least one head nurse in the last three months of the situation analysis in IHP-supported health zones



3. **Availability of medications:** The availability of medications was evaluated based on tracer medications for the treatment of malaria, diarrhea, and pneumonia in children in accordance with national policy on treatment at the community level. Table 5 shows that 40.6%, or 140 CCM sites, had completely run out of tracer medications to treat simple cases of malaria (ACT), diarrhea (SRO-Zinc), and pneumonia (Cotrimoxazole) in sick children on the day of the assessment.

Table 5: Number (proportion) of CCM sites with tracer medication shortages on the day of the inventory of the health zones targeted by IHP

Medications	No. of CCM sites with inventory shortages (N=345)	%
ACT (ASAQ)	199	57.7
SRO	202	58.6
SRO & ZINC	163	47.2
COTRIMOXAZOLE	212	61.4
All Medications	140	40.6

4. **Incorporation of family planning activities into CCM sites:** Of the 345 existing CCM sites, 40 (12%) had incorporated community-based family planning activities, with a total of 70 community health workers deployed across five health zones. Roughly half of the 40 CCM sites offering FP services had FP commodity shortages: 50% of the sites had stock outs of male condoms; 42.5% had stock outs of cycle beads; and 62.5% CCM sites had stock outs of contraceptive pills. The Lubondaie health zone in of Kasaï Occidental province had completely run out of these three commodities on the day of the assessment.

Table 6: Distribution of new family planning users recorded by the CCM sites of five health zones in the last six months

Province	Health zone	No. of users in the last 6 months	Monthly average
Kasaï Occidental	Lubondaie	69	11
	Tshikaji	172	29
	Bibanga	63	11
Katanga	Songa	428	71
	Lualaba	2	0
Total		734	122

Overall, Table 6 shows that 734 new family planning users were received in the last six months in the CCM sites, with the Songa health zone sites reporting the greatest number of new family planning clients. Although the Lubondaie health zone had completely run out of commodities on the day of the visit, it received 69 new users in the six months before the shortfall. The full report of the assessment of CCM site functionality will be available in October 2011, and the results will guide IHP in designing and implementing a plan for revitalizing and further strengthening CCM sites.

Activity 4: Scale up evidence-based community WASH pilots

IHP is now implementing its approved water, sanitation, and hygiene (WASH) strategy through all eight coordination offices, starting with training of trainer sessions on participatory approaches for community mobilization on WASH and the IHP WASH technology package. The overall strategy is

designed to sensitize communities, organize them to form WASH committees, and involve them in participatory action to construct household WASH facilities.

To influence national WASH policy and strategies, IHP and other key actors in this domain--including UNICEF, the national direction of hygiene in charge of coordinating the "clean village program," and the national coordination of WASH activities–agreed to organize a workshop to evaluate the national policy and align the partners' various implementation strategies, early in PY2. The IHP WASH advisor has been asked to join the national WASH task force group which holds weekly meetings either at the MOH or at the Ministry of National Investment Planning.

During the fourth quarter, IHP conducted WASH management activities in target communities. Each of the 10 IHP WASH specialists selected at least two communities in which to begin implementing activities including community mobilizing and awareness of the importance of appropriate water, sanitation, and hygiene facilities, and the creation of community WASH committees (C-WASH-Cs) with a balanced make-up of representatives by gender and age. In this quarter, 28 communities (10 of them in the IHP coordination of Tshumbe) were reached, with a total of 196 people including 75 women trained in community WASH management issues such as: (i) community work for the construction of public and household WASH facilities in the village, (ii) cost recovery aspects for the exploitation and maintenance of community WASH facilities, (iii) community representation for the governmental WASH authorities.

The detailed approach for the implementation of the WASH management for communities is the same as the one used in the "clean village" program, aimed at empowering and/or involving communities in the "clean village" process. Step one of this process requires that, after a letter of request is sent from the community to the MOH representative in the health zone, agreements be signed between the community and the MOH; these agreements have been signed between the MOH (represented by the health zone officer) and the enrolled communities in Sud Kivu (IHP Coordination of Uvira) and Western Kasaï (IHP coordination of Luiza). The next step is to create a WASH committee in the community, which is then responsible for conducting a WASH baseline study using a questionnaire provided by the MOH. This participatory diagnosis on community WASH issues results in a community workplan designed to address any gaps. The workplan is implemented and evaluated by the BCZ, and if successful, the community is certified as a "clean village."

A WASH consultant began conducting five-day training of trainers (ToT) sessions on the IHP WASH package in Bukavu (for Sud Kivu), Lubumbashi (for Katanga), and Kananga (for the Kasaï Occidental and Kasaï Oriental provinces), followed by preliminary site visits and recommendations to six sites in Bukavu and three in Kolwezi, assistance with the facilitation of introductory village meetings with the participation of traditional leaders and health zone staff, and the presentation and discussion of community projects. During the current reporting period, two ToT sessions were conducted in Kolwezi (for the IHP Katanga offices) and in Kananga; the last session is scheduled in Bukavu (for IHP Sud Kivu IHP) during the next reporting period. These trained 48 trainers (23 in Katanga and 25 in the Kasaï Occidental and Kasaï Oriental provinces) in theory and application of the IHP WASH package, strengthening their ability to construct: (i) water springs; (ii) biosand filters; (iii) hand washing equipment; (iv) household and public separate VIP latrines for men and women; and (v) safe drinking water storage equipment (PEP[1]). The consultant also held group discussions on the next steps following the training and assisted participants with completing an evaluation of each training session.

[11] Poste d'eau Potable

Following the ToT sessions, the 10 WASH specialists were assigned to conduct training sessions for at least 20 persons each, targeting artisan-masons from 20 communities which had been previously sensitized, to further involve them in the construction of the WASH facilities. Due to an air crash and subsequent closing of Hewa Bora Airlines, there has been a drastic reduction of travel possibilities to Bukavu, Kolwezi, and Kananga. In addition, it was difficult to schedule community mobilization sessions within the planned timeframe as the sessions took longer than initially envisioned; nevertheless, two of the three sessions (in Kolwezi and Kananga) were held. Additional training sessions will be completed in the first quarter of PY2.

IHP organized three ToT sessions for 80 trainers (participants came from the national direction [D9] and the provincial offices [B9] of hygiene--25 in Bukavu, 25 in Lubumbashi, and 30 in Kananga) on the Community-led Total Sanitation (CLTS) and Participatory Hygiene and Sanitation Transformation (PHAST) approaches. The PHAST training covered theoretical, practical, and context-specific information and techniques. The training focused on new technologies, such as the construction of Ventilation Improved Pit (VIP) latrines with two and three pits, construction of hand washing stands from fibro-cement, biosand filters, and the creation of drinking water posts and capping springs that can provide clean drinking water. The training also included a practical element--constructing two hygienic latrines--one for a family and another at the Kanina health center in Dilala health zone, as well as the installation of a water source in Kanina health area, and hand-washing units in Kanina health center. Self-esteem, associative strengths, resourcefulness, action planning, and responsibility (SARAR) community participation tools were also presented to complement the PHAST approach. The CLTS approach promotes the mobilization of communities to completely eliminate open defecation through a participatory process of self-evaluation and analysis, rather than focusing on a top-down latrine building approach.

The consultant engaged for this activity was subsequently re-contracted by Action Against Hunger's Bukavu office to train their personnel on the same themes. Later, the international NGO Association of Volunteers in International Service (www.avsi.org) operating in Sud Kivu, requested that IHP Bukavu office deploy an IHP trained staff member to train 15 of their community mobilization workers. This was completed successfully to the satisfaction of the AVSI team.

Improving access to safe drinking water: Based upon the assumption that one water point (water spring, improved well or another type) serves about 150 households of six persons each, the project reports the following results this quarter:

- Sud Kivu: 3,000 persons with improved access, following the completion of three water springs constructed with project funds
- Kasaï Occidental: 2,700 persons with improved access, following the completion of two water springs and one improved well in the Luiza and Tshikaji health zones.
- Kasaï Oriental: 3,600 persons with improved access, due to four water springs constructed in Mwene Ditu.
- Katanga: 900 persons with improved access, due to one water spring constructed in Kolwezi.

IHP distributed 60-liter drinking water pots (228 in Luiza, 240 in Mwene Ditu, 125 in Tshumbe, 140 in Kole, 260 in Kamina, 128 in Kolwezi, 113 in Bukavu, and 25 in Uvira). The drinking water pots allow for the safe storage of drinking water, avoiding contamination. Water quality in these containers will be tested in PY2, and based on the results, IHP will decide whether the systematic distribution of purification tablets to ensure water quality is needed. In Uvira, the health zone management team

identified five drinking water sources, and IHP is in the process of rehabilitating them. IHP rehabilitated four water sources in the health zone of Miti-Murhesa (Bukavu), in the villages of Maseka, Luamuzungu, Kabikerhe, and Karhabisha.

Improving access to hygienic latrines: A total of 1,020 people now have access to hygienic latrines due to IHP-supported activities in communities.

- In Sud Kivu, 600 people have access to 110 improved household latrines (66 in Bukavu and 54 in Uvira).
- In Kasaï Occidental, in the health zones supported by the Luiza coordination office, 360 people have access to 60 improved household latrines.

Photo 2: Construction of a two-pit family latrine in Manika

Photo 3: Construction of a VIP latrine for a household in the Tshikaji health zone, Kasaï Occidental

In Uvira, IHP started work on latrine construction. In the Ruzizi health zone, IHP delivered construction materials to build family latrines, and the work is underway. With technical assistance from the health zone management teams and IHP staff, 134 family latrines were constructed in Ruzizi and an additional 32 in the health zone of Lemera. IHP supported WASH community education activities, and residents who agreed to construct latrines were assisted by the IHP and the health zone's WASH representative to install hygienic family latrines. In addition, one incinerator was constructed at the Mulongwe health center in Uvira and a second at Kavumu hospital in Miti-Murhesa (Bukavu).

The IHP Bukavu office facilitated an assessment in three villages in the Miti-Murhesa health zone and three villages in Katana, which resulted in the distribution of 110 wooden slabs and the training of community members on how to install them. IHP also started rehabilitation work on the latrines in Bagira maternity center and the General Reference Hospital. In Kolwezi, the sand and gravel required for the production of 250 concrete slabs in Mupanja and Lualaba health zones was delivered; actual production will begin early in the next quarter.

IR 1.3 Provincial management more effectively engaged with health zones and facilities to improve service delivery

Activity 1: Conduct an adapted senior-level Leadership Development Program (LDP) for provincial-level management team (Equipe Cadre) and district-level management team

IHP continued to provide capacity building on leadership. The IHP Luiza office conducted workshop one of the Leadership Development Program (LDP) for 25 members of the management teams from the four former AXxes project health zones (Bulape, Mutoto, Lubondayie, and Tshikaji). The Mwene Ditu office organized consecutive LDP training for 22 male trainers from the provincial health division team and a workshop for 28 participants from the six former AXxes project zones (Dibindi, Bibanga, Lusambo, Pania Mutombo, and Mpokolo). In addition, the Kolwezi office organized an LDP ToT, with the participation of DPS, DS, and IHP staff from Katanga, as well as IHP and health district staff from Uvira. A similar activity was carried out in Bukavu in the last quarter. All coordination offices went on to train ECZS representatives in their respective areas. The breakdown of those trained can be found in Table 7.

Activity 2: Provide support to fully develop systems for provincial oversight of health services

In addition to the financial support provide monthly to the DPS by the eight IHP coordination offices, IHP reinforced provincial involvement and oversight of health activities through FOSACOF and LDP training and orientation activities for provincial authorities, e.g., senior alignment meetings and trainings of trainers. These activities were conducted in all four provinces.

Activity 3: Provide support to provincial-level strategic planning, coordination, and communication

In the current reporting period, the Uvira team participated in a coordination meeting for organizations working in the area's health sector. The meeting allowed participants, representing many different international NGOs, to understand what each group is doing and how they can better coordinate.

Activity 4: Provide provincial and district levels with the support needed to actively engage with the heath zones and facilities to improve service delivery

All IHP coordination offices provided technical assistance and financial support to the DPS, districts, and health zones to carry out their activities. Health zone operational costs continued to be provided by MSH since the health zone grant mechanism is not yet approved by USAID. IHP distributed management tools and petrol for the cold chain in all health zones. In Kolwezi there was a delay in providing the

support for August and September 2011 because the process of clearing the July disbursement with needed support documentation took more time than expected. IHP provided an additional orientation to procedures to strengthen partner management capacity.

Intermediate Result 2: Quality of MPA/CPA-plus services in target health zones increased

IR 2.1 Clinical and managerial capacity of health care providers increased

Activity 1: Reinforce competency-based training for specific identified skills

In order to improve the quality of care and availability of services, several training sessions were carried out by all IHP coordination offices for provincial, district and health zone staff, as well as service providers and some community members. A summary of the various training sessions is included below:

Table 7: Summary of competency-based training in Q4

N°	Training	Participants	Total individuals or groups trained	Location	Comments
1	WASH Approaches	Doctors, Nurses, Rural Development Technicians, BCC/IHP and DPS	82	Luiza, Mwene Ditu, Tshumbe and Kole Bukavu and Uvira Kamina and Lubumbashi	Training in 3 "pools" (Bukavu, Lubumbashi, and Kananga)
	WASH Technologies	Doctors, Nurses, Rural Development Technicians, Technical Specialist/IHP and DPS	25/Luiza	Luiza, Mwene Ditu, Tshumbe and Kole Kamina and Lubumbashi	Training in 2 pools (Kananga & Lubumbashi)
2	EPI/MLM (Vaccination)	ECZS/SK	32	Bukavu and Uvira	28 ECZS IHP and 4 non-IHP supported ECZS non IHP (trained with DfID support). 83 members of 32 ECSZ/SK
	EPI/Providers	Providers	183	Luiza	
3	Malaria	ECZS	18	Luiza and Mwene Ditu	10 ECZS LUIZA (But LUIZA/FM) 8 ECZS Mwene Ditu (but Kandakanda, Dimbindi & Mwene Ditu, trained by GF). Total =36 members of 18 ECZS.
		Providers	462	Luiza and Mwene Ditu	174 at Luiza & 288 at Mwene Ditu
4	HIV Integrated package	Doctors, Nurses, TL & pharmacists	134	Mwene Ditu and Kamina	Kamina : 60 achieved so far – Mwene Ditu: 74
5	HIV Blood safety	Volunteer blood donors	79	Bukavu and Uvira	49 Bukavu and 30 Uvira
6	Family Planning	Providers	117	Tshumbe	ZS Lodja, Omedjandi, and Vangakete
		CBD	564	Kamina and Tshumbe	285 Tshumbe (ZS Lodja, Omedjandi,

					and Vangakete) and 279 Kamina
7	SNIS	Members of 4 ECZS	24	Kole	HZs of Lodja, Kole, Omedjandi, Benadibele, Vangakete, Lomela, and Tshudiloto
		Providers	118	Kole	
8	Kangaroo Mother Care	Technical specialists IHP, providers from 2 HGR of Dilala and Panzi and MOH	32	8 IHP Field Offices	Training held in Kinshasa
		ECZS and DS	36	Kolwezi	8 ECZS, Kolwezi
		Community leaders	28	Kolwezi	8 ECZS , Kolwezi
9	FOSACOF	ECP/SK and DS	32	Bukavu and Uvira	
		ECZS	16	Bukavu (11), Uvira (5)	80 members trained
			5	Luiza	25 members trained
			5	Mwene Ditu	25 members trained
			9	Kamina	45 members
			3	Kole/Tshumbe	Lodja, Omedjandi, and Vangakete
		Providers	165	Luiza	55 FOSA FOSACOF
			262	Mwene Ditu	55 FOSA FOSACOF
			150	Tshumbe	50 FOSA FOSACOF
			100	Kole	20 FOSA FOSACOF
10	LDP TOT	ECP/Lubumbashi +DS/ Kolwezi and Haut Lomami	26	Kamina and Kolwezi	
	LDP Senior Alignment Meeting	SAM	120	Mwene Ditu, Kolwezi, and Kamina	
	LDP Workshop 2	ECZS	45	Kamina	
			40	Kolwezi	
			55	Bukavu	
11	Flowcharts	ECP and DS	20	Mwene Ditu	
			20	Luiza	
		ECZS	11	Mwene Ditu	60 members trained
			11	Luiza	22 members trained
			14	Tshumbe and Kole	70 members trained
			8	Kolwezi	40 members trained

Activity 2: Reinforce supportive supervision skills in support of ECZ monitoring health facilities

IHP modified its supportive supervision model in the Sankuru health district, and more specifically in the Kole, Bena, Dibele, and Lodja health zones. The approach consists of randomly selecting two or three checklists from the supervision grid. These checklists are used to collaborate with health training service providers (FOSAs) to identify and analyze potential problems associated with the quality of service offerings, specifically the failure to follow standards and procedures in the area of service delivery. The deficiencies associated with the skills of service providers are corrected on site by planning exercises on an anatomical model (mannequin) and/or on patients. Several demonstration sessions and training in pairs are carried out based on the skills to be strengthened and the level of deficiency to be corrected. Overall, 22 service providers, including 10 in Kole and 12 in Bena Dibele, received capacity strengthening through this supportive supervision approach. IHP took advantage of its participation in the quarterly review of the Sankuru health district, held in Lodja, to provide orientation on this supportive supervision approach to IHP staff from Kole and Tshumbe, 14 health zone management teams, and the coordinators

of health district specialist programs present at the meeting. Supportive supervision also took place at the Lodja maternity center in the presence of its entire team, district and health zone supervisors.

In addition, IHP accompanied health zone management teams (ECZ) on joint supervision visits to the health zones, which enabled them to identify problem areas and define priorities for support. IHP arranged for the repair of motorbikes received by health zones under the former AXxes Project to increase the mobility of ECZ.

Activities 3 – 60: Implement both pre-service and in-service training and refresher training programs in the areas of MPA and CPA-plus in the targeted health zones, aligned with ongoing SPS training on pharmaceutical management and supervision

Health zone supervision visits to the health zones enabled IHP teams to reinforce the capacities of service providers through supportive supervision rather than formal training programs. In particular, supervisors learned that poor stock management issues exist at all levels.

During Data Quality Self Assessment supervisions, IHP noted discordance between data in the register, on vaccination cards, and that in SNIS reports. There was also a stock-out of some printed materials such as the vaccination register and the pre-school consultation sheets. Moreover, those places that had these materials were not using them correctly. Targeted training on all of these issues will be carried out in Y2.

Activity 4: Family Planning

Two IHP staff, including a health zone supervisor and a DBC agent from Luiza, participated in the Second Africa Region Family Planning Conference in Nairobi in July 2011, as part of the DRC country delegation. The theme was *Effective Community Approaches to Family Planning*.

The purpose of the conference was to share promising best practices in family planning to foster community ownership, strengthen and expand community awareness for better health impact, and improve maternal and infant services, youth programs, smart integration and coordination all levels of the community. Similar to other country delegations, the DRC group set out an action plan which the IHP will support in year 2.

IHP supported the National Reproductive Health Program (PNSR) technically and financially to collect the data needed to finalize the mapping of family planning practitioners and activities in the 80 project-supported health zones. The data collection also enabled PNSR to obtain information regarding the inventory of existing equipment, the status of inputs, and available IEC materials.

In September, IHP organized family planning training sessions to train 117 service providers in the Lodja, Omedjandi, and Vangakete health zones and 564 community-based distributors, including 285 from the Tshumbe health zone and 279 from the Kamina health zone.

IHP strongly recommends that community-based distributors (CBDs) continue to be trained in the other health areas not covered by IHP because the involvement, presence, and service offered by the CBDs greatly influences the results obtained in raising awareness, counseling and the number of new family planning users. In PY2, if budget permits, IHP will train 5,050 new CBDs and provide them with bicycles and kits (FP commodities, boots, umbrella, bag, etc.).

The monitoring and training of the CBDs by head nurses will need to be further strengthened through regular supervisory visits in order to motivate the CBDs and improve their technical capabilities.

The effective integration of family planning at the different levels of reproductive health care (prenatal consultation, child birth, post-natal consultation, pre-school consultation, PMTCT) and CCM sites is part of a new project initiative for the next year. IHP will establish a platform of all community-level service providers (site health workers, community health workers, CBDs and promotional and institutional health workers) with a clear and precise identification of roles and responsibilities of each stakeholder.

Key activities for PY2 will include strengthening the capacity of services providers and members of the management team to manage contraceptive products; and training service providers to apply long-term clinical methods such as IUD, implants, vasectomy, and tubal litigation.

During PY1, IHP achieved a value of 431,878.96 couple years of protection (CYP) provided by FP services, surpassing the PY1 target of 318,854, based upon the volume of all contraceptives provided to clients in the IHP target areas during a one-year period. Figure 4 presents a CYP breakdown by quarter.

Figure 4: PY1 Couple Years Protection by quarter in IHP-targeted health zones

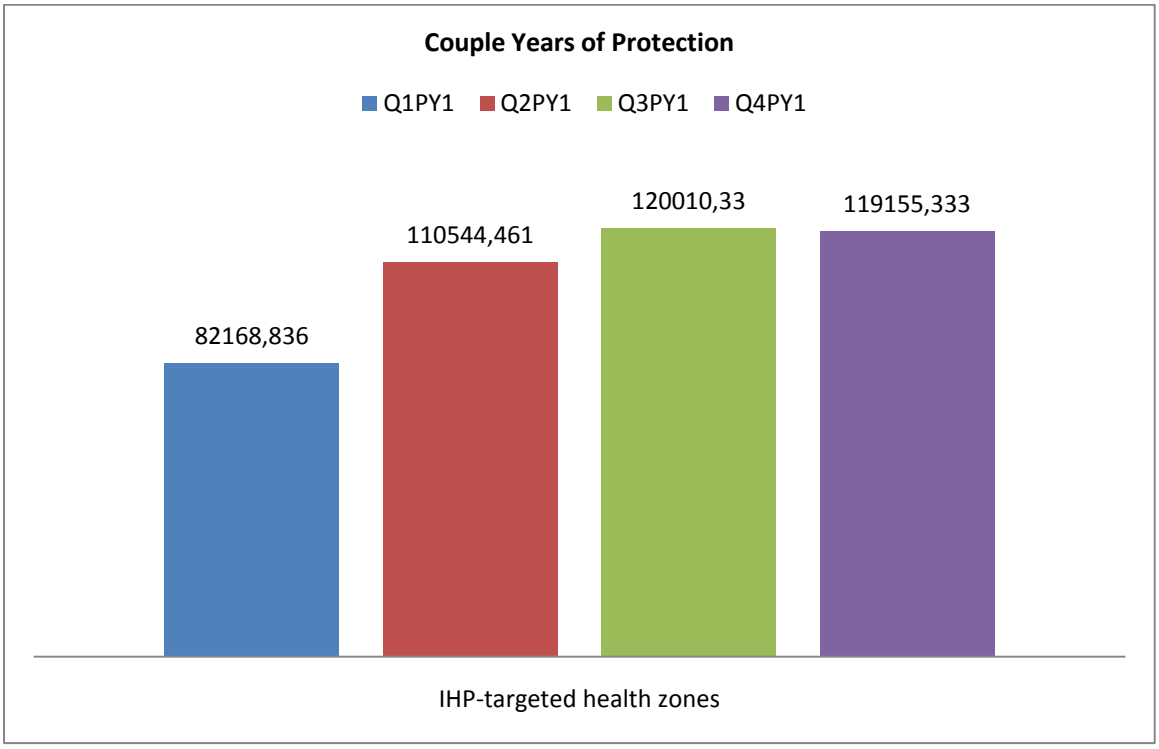


Figure 5: Number of acceptors of modern family planning methods by coordination office and by quarter

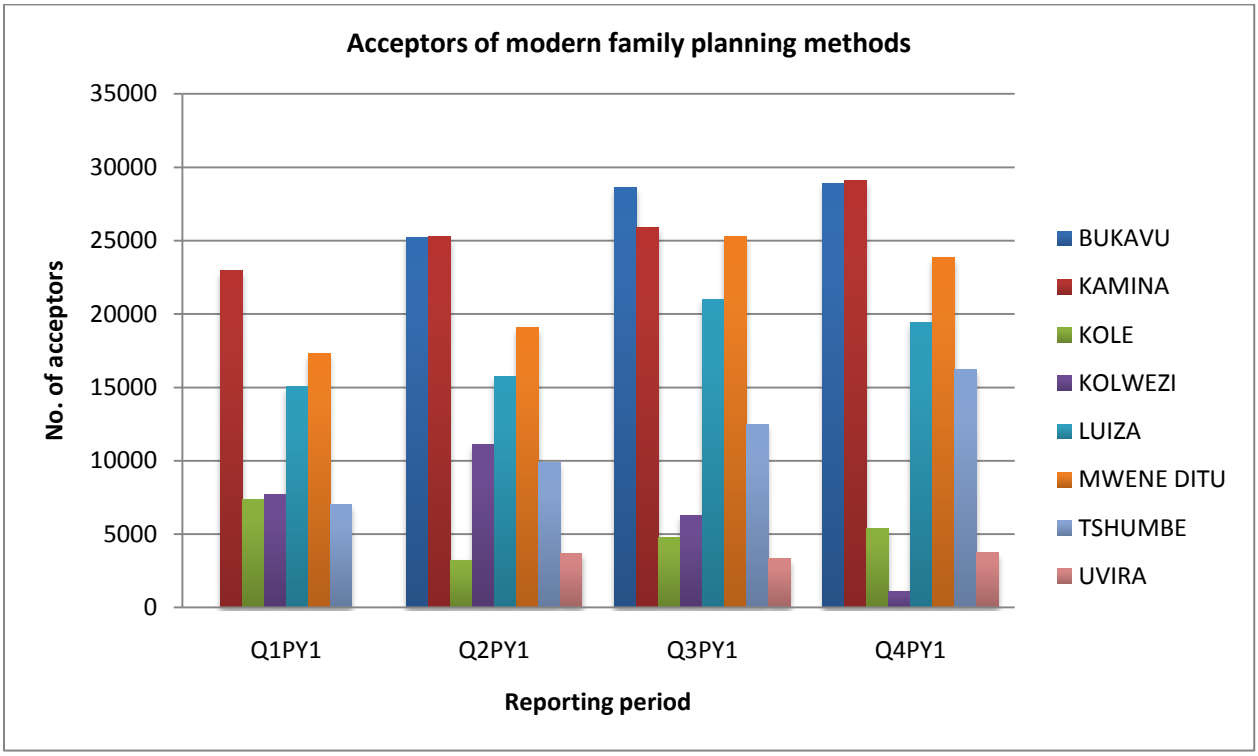


Figure 6: Number of acceptors of clinical family methods by coordination office and by quarter

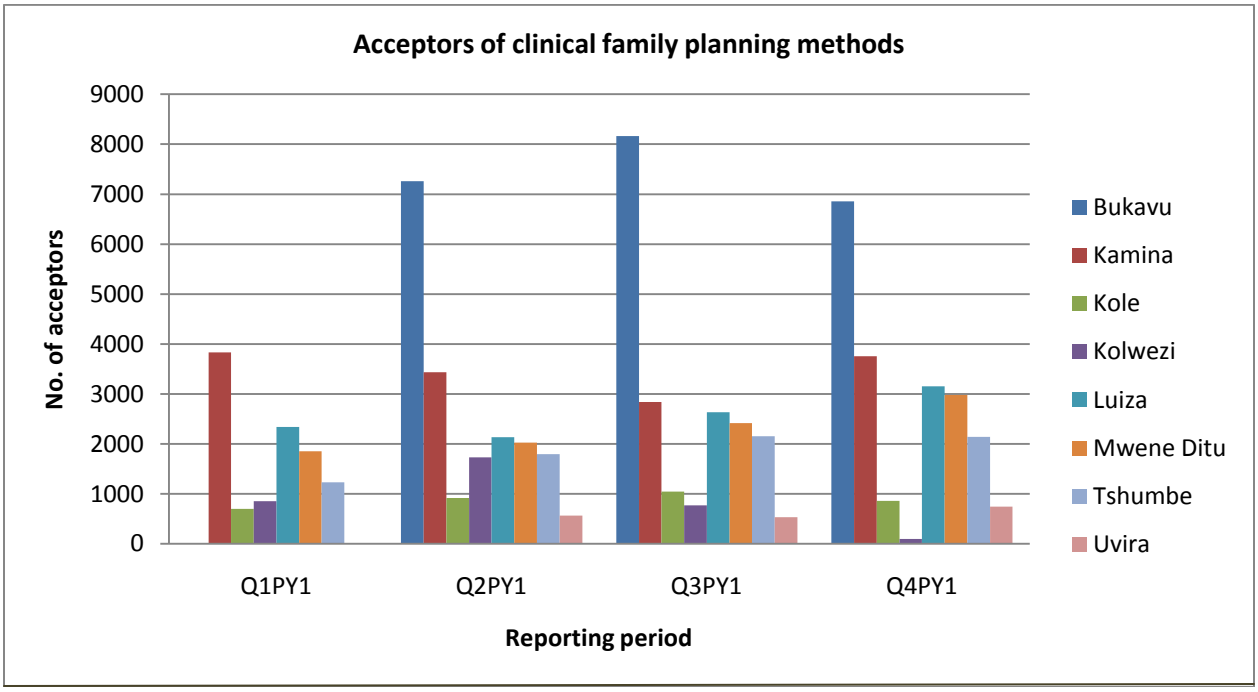
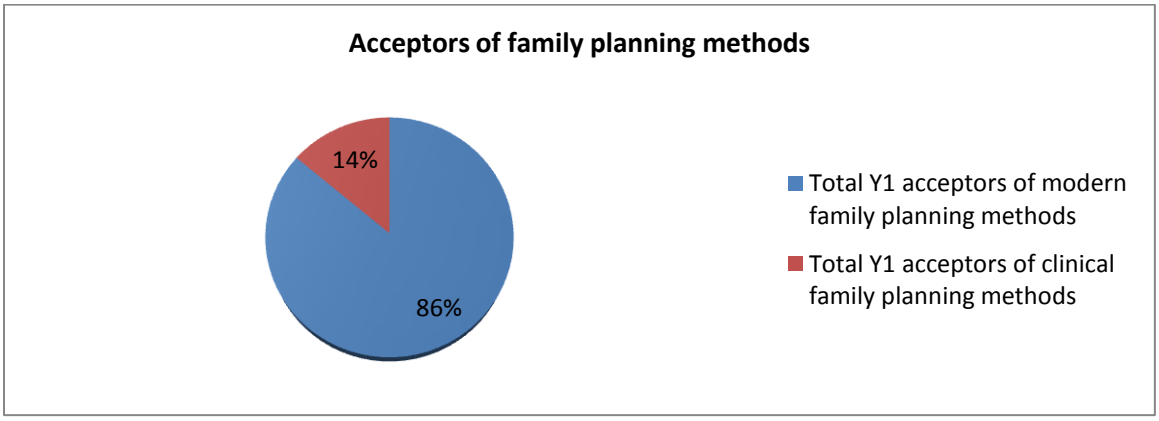


Figure 7: Total number of acceptors of family planning methods during PY1



During PY1, 86% (445,772) of individuals who practice family planning accepted modern methods while 14% (71,776) accepted clinical family planning methods.

Activity 5: Immunization

IHP is training EPI team members at EPI satellite sites and health zones on how to effectively manage vaccination services and apply data quality self-assessment (DQS) tools to improve the quality and performance of vaccination services in health centers. During the fourth quarter, 113 managers and management teams of health zone central offices and of the district were trained, surpassing the target of 72 people. Partners from the Sud Kivu provincial inspection and some EPI partners (such as IRC) funded the training of managers in health zone teams not supported by IHP.

In the Luiza coordination area, IHP trained 11 senior medical officers, 11 supervisory nurses and 11 logisticians in mid-level management and data quality self-assessment (MLM/DQS). In the Bukavu and Uvira coordination areas, in conjunction with the provincial health office (IPS) and the other EPI partners in the province, all members of health zone management teams, health districts and EPI satellites were trained. In total, 88 people were trained.

Table 8: Recipients of MLM/DQS training by institution, function, and sex in Sud Kivu, August 2011

	INSTITUTION	CATEGORY				SEX		
		Doctor	Nurse	Logistician	TOTAL	M	F	TOTAL
1	IPS	0	2	0	2	2	0	2
2	EPI satellite sites	0	5	5	10	8	2	10
3	Central Office	31	38	0	69	69	0	69
4	Hospital	2	2	0	4	4	0	4
5	IHP	1	1	0	2	1	1	2
6	Other partners	0	1	0	1	0	1	1
	Total	34	49	5	88	84	4	88

Source: Sud Kivu

In addition to the above training, IHP supported the training of 183 service providers in the Luiza coordination area in the mid-level managers course.

During the fourth quarter of PY1, IHP provided 45,694 liters of oil and 1,130 liters of Gasoil to support cold chain material, and 721 wicks, 250 burners, and 114 glasses (No. 8, 23, and 32) for the repair and maintenance of the cold chain material equipment. In addition, IHP supplied 156,000 0.5 ml self-locking syringes to cover a stock out in the health zones of the Kolwezi and Luiza coordination areas; IHP also transported 3,150 tons of vaccinations and other inputs to the Sud Kivu EPI coordination area. In the Luiza coordination area, IHP transported a refrigerator donated by the WHO to the Nkuna storage site in the Yangala health zone to replace a unit damaged by fire.

Monitoring and response campaigns targeting 35 health zones in the Kole, Tshumbe, Mwene Ditu, Luiza, and Kamina coordination areas took place during the quarter. Overall, 863,941 infants from 6 to 59 months were vaccinated out of a target of 852,566 or a rate of 101.3%. In the 35 zones that conducted the measles monitoring campaign, IHP participated in coordination meetings through coordination committees, in campaign evaluation meetings, carried out hands-on supervision, and ensured that outreach strategies were implemented to reach difficult to access and special populations in each target health zone. In the Luiza coordination area, IHP coordinated the response vaccination activities in the Dibaya health zone with financial support from WHO.

In the context of introducing a new PCV13 vaccination in Bukavu and Uvira, IHP supported the production of the revised reporting tools for the target health zones. IHP also provided transportation of vaccinations for Sud Kivu, consisting of 3,518 KG of vaccinations to Bukavu for the introduction of PCV13.

In support of and with the collaboration of the National Vaccination Program, IHP completed an inventory of equipment and cold chain materials in the 80 health zones. The situation of cold chain materials is summarized in the table below.

Table 9: Distribution of equipment by age and by energy source in the health zones supported by IHP and their support satellites

		Sources of energy used			
Equipment (refrigerator)	Total number	Electricity	Oil	Solar	Gas
Equipment age unknown	2	0	2	0	0
Equipment <= 5 years	603	94	366	142	1
Equipment >5 years & <10 years	280	68	205	7	0
Equipment > 10 years	90	19	68	3	0
Total equipment	**975**	**181**	**641**	**152**	**1**

At the 13 EPI satellites and storage sites supported by IHP, there are 975 refrigerators and freezers including 641 that use oil as a source of energy, 181 that run on electricity and 152 that use solar energy. The cold chain equipment for the central offices is insufficient for introducing the new PCV 13 vaccination because 24 additional refrigerators are still needed to fill the gap. IHP has noted that 370 of the cold chain units are more than five years old and have not been regularly maintained.

In the context of preparing national vaccination days during the quarter, IHP participated in the Interagency Coordinating Committee (CCIA) technical conference, in four conferences of the epidemiological oversight cell, and in a conference of the national coordination committee. IHP also produced data management tools for the Kole, Tshumbe, Mwene Ditu, and Kamina coordination areas, and others are underway for the Bukavu, Kolwezi, and Uvira coordination areas. The project produced

revised management tools: 806 no. 1 forms; 440 no. 2 forms; 440 no. 3 forms; and 440 score cards, revised the EPI technical records, and produced 1,500 copies of these records for vaccinating structures. A supplementary production round of these tools and the vaccination coverage monitoring grid is currently underway.

During the quarter, the project conducted data quality audits in six priority health zones using the DQS tool: in Kole, Bena, and Dibele in the Kole coordination area, and Ibanda, Bagira, Miti Murhesa, and Kadutu in the Bukavu coordination area.

Corrective plans were prepared for the health zones in order to improve the quality of vaccination data. The following vaccination components were evaluated: planning, vaccination management, follow up and monitoring, formative supervision, archiving, and vaccination safety.

In general, the planning, vaccination management and vaccination safety components are still weak in the Kole coordination area. In the Bukavu coordination area, vaccination management, archiving, and monitoring components need to be closely watched for improvement.

During the quarter, IHP supported a response to a measles epidemic in Kasaï Oriental, including the four health zones (Kalenda, Kanda Kanda, Luputa, and Mwene Ditu) supported by the Mwene Ditu coordination area. From the 14th to the 25th week of the epidemic, 10,137 cases of measles were reported in Kasaï Oriental, including 144 deaths. The province and the national level adopted several strategies to prevent the spread of the epidemic, notably, strengthening routine EPI, organizing response and monitoring campaigns, strengthening surveillance, raising community awareness, and treating cases. In addition to technical and financial support, IHP received a treatment kit for 10,000 cases of measles from the WHO. This contained 185 items including oral and injectable medications, topical treatments, medical supplies, and documentation for health facilities.

Table 10: Number of cases of measles reported and treated in the health zones supported with the WHO-provided treatment kit

Health zone	Cases reported				Cases treated			
	0 - 11 months	12 - 59 months	< 5 years	Total	0 - 11 months	12 - 59 months	< 5 years	Total
Kalenda	141	515	275	931	141	515	275	931
Luputa	576	943	336	1855	329	549	205	1083
Mwene Ditu	28	7	2	37	28	7	2	37
Kanda Kanda	93	434	174	701	93	434	174	701
TOTAL	838	1899	787	3524	591	1505	656	2752

Cases were treated between July 29 and September 2, 2011. During that period, 3,525 cases of measles were reported, including 2,752 cases which were treated and cured (78%).

The Luputa health zone recorded the highest percentage cases (i.e., 53%). UNICEF provided medications in the health zone, accounting for the proportion of cases treated, which was 58% compared to the number of cases reported. The Mwene Ditu health zone reported only one percent of cases. This was due to the fact that the measles vaccination campaign took place in May and Médecins Sans Frontières (MSF) and the MOH organized treatment of cases there in the context of health training.

Activity 6: Maternal, child, and neonatal health

During the fourth quarter, IHP finalized the integrated Maternal, Newborn and Child Health (MNCH) Advisor recruiting process, and then hired an international consultant to support the project in this area for a month. The consultant assisted with the design of effective newborn health interventions and developing an implementation plan while also training the new MNCH Advisor. She also co-facilitated the Kangaroo Mother Care (KMC) training, and provided technical assistance on newborn care within the framework of integrated care for the mother and the newborn, including support for the expansion of community- and facility-based essential newborn care and improving care for low birth weight infants. The consultant worked with IHP staff to review the package of interventions for scaling up and strengthening evidence-based community interventions as well as revisions to the training modules and tools (such as a new partogram with special relevance to newborn care, supportive supervision framework, etc.). She reviewed current issues and how to best use the new materials and tools to support IHP's objective of improving the quality in this area.

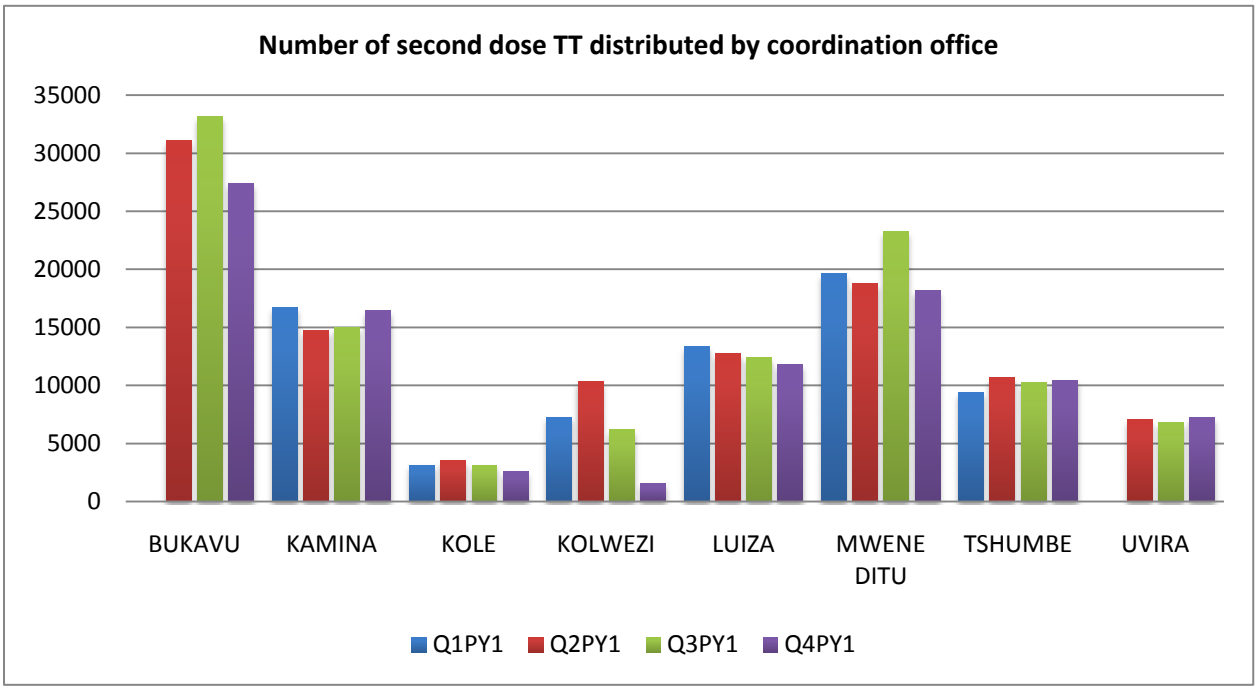
The Kolwezi and Bukavu coordination areas presented the KMC training to ECZ's and community leaders. IHP is procuring materials to launch the Bukavu and Kolwezi centers of excellence in Panzi HGR and Dilala HGR, respectively, including rehabilitation work on the KMC unit.

Helping Babies Breathe (HBB): IHP met with representatives of the Church of Latter-Day Saints to discuss options for collaboration in the context of training HBB trainers, and agreed to start with a group of 40 people in project-supported intervention zones in April 2012. The Church will support the modules and training materials (mannequins) as well as cover costs related to travel and accommodation for the trainers. Refresher training for HBB service providers is a priority in the IHP PY2 workplan.

MNCH standards and directives: A team of experts from the MOH and various partners finalized the document on standards and directives for integrated maternal, newborn and child health, which was then transmitted to the national technical commission for feedback and comments prior to validation proper at the national level. IHP contributed technically and financially to the preparation of the document, and subsequently planned a meeting to validate it in the PY 2 workplan. Clinical IMCI is included in the training on flowcharts, which was provided to all IHP coordination offices during this reporting period. IHP will provide this training to health care providers during the next reporting period. IHP will coordinate activities with the IMCI focal points at the provincial level.

The following figures confirm IHP baseline survey findings that Kole, Kolwezi, and Uvira are performing at a low performing in maternal, child, and neonatal health. These gaps have been considered in PY2 workplanning priorities.

Figure 8: Number of Second Doses of Tetanus Toxoid Vaccine (TT) administered



During PY1, 384,079 pregnant women received a second dose of tetanus toxoid vaccine.

Figure 9: Number of women benefiting from Active Management of Third Stage Labor (AMTSL) compared to deliveries with a skilled birth attendant

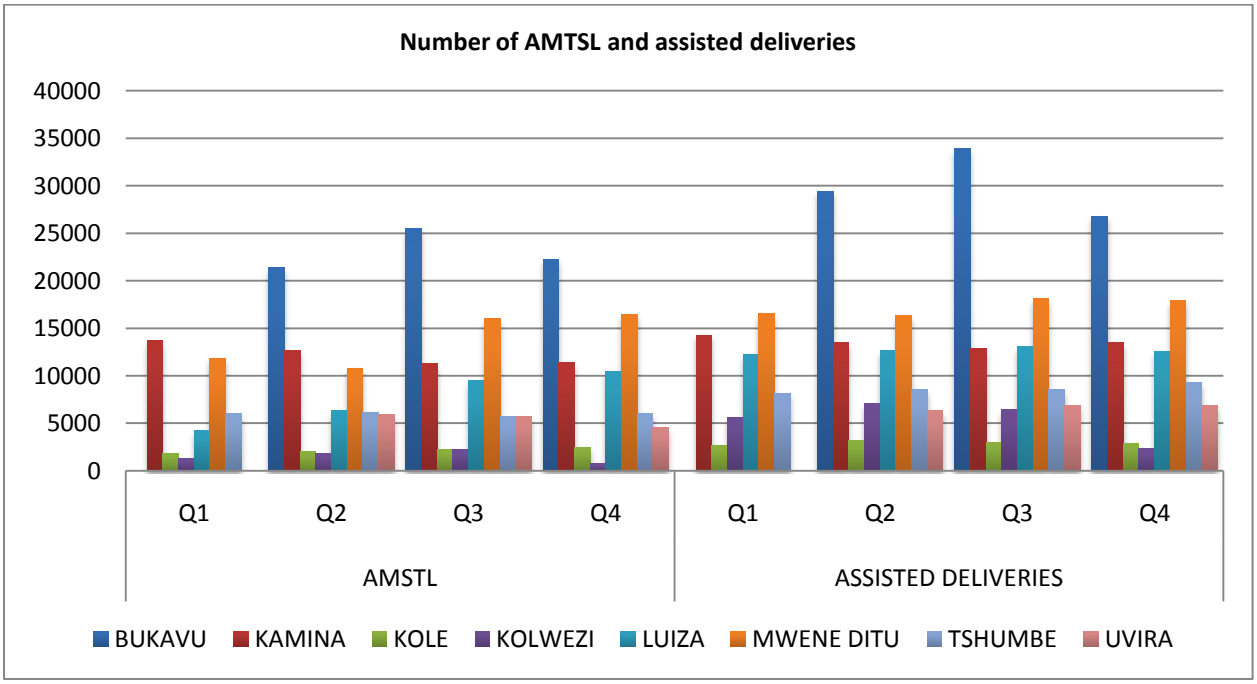
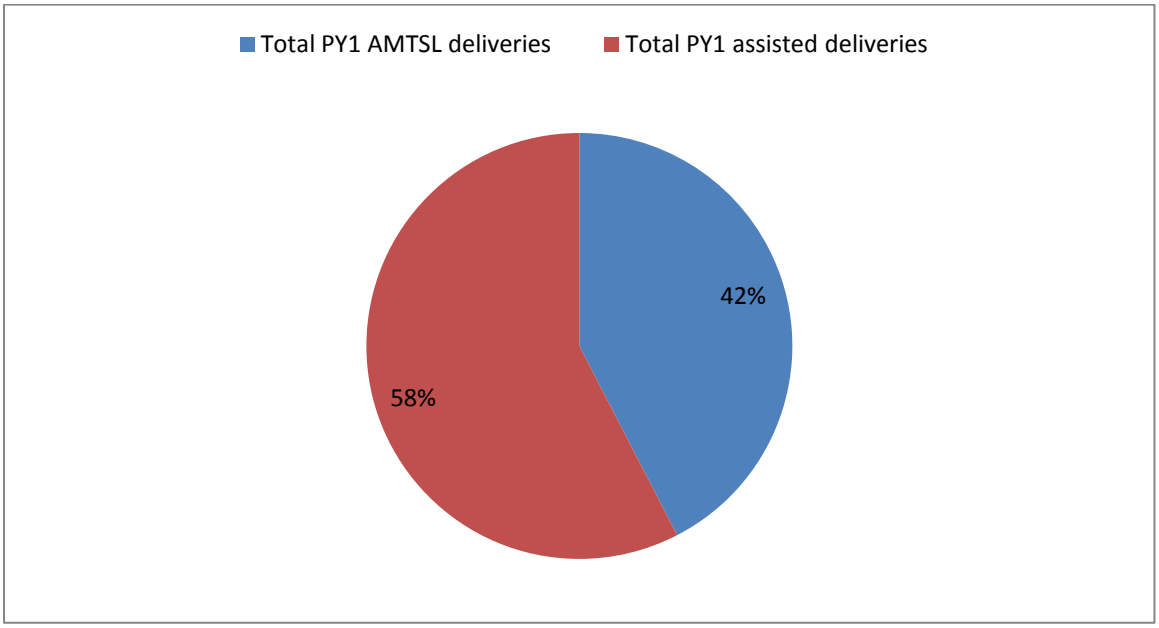


Figure 10: PY1 cumulative number of AMTSL and assisted deliveries



About 58% (258,813) of women who delivered in IHP-targeted health facilities benefited from the AMTSL method while 42% of women (351,511) giving birth were assisted by skilled birth attendants.

Activity 18: Malaria

During the fourth quarter, IHP trained 462 health care providers from 18 health zones in two provinces on malaria prevention (LLINs, ITP) and case management using the new protocol (updated national guidelines require malaria diagnosis prior to any treatment with ACTs) and rapid diagnosis tests (RDTs): 288 people in Kasaï Oriental, and 174 from Kasaï Occidental. IHP participated in joint supervision of the provider training with the National Malaria Control Program to oversee the quality of the training. Providers from four IHP targeted health zones also supported by the Global Fund (Luiza in Kasaï Occidental; and Mwene Ditu, Kanda Kanda, and Dibindi in Kasaï Oriental) were not included in this training because the Global Fund had previously conducted a similar training.

The training of providers was preceded by a training of trainers for 22 representatives of health zone management teams in Kasaï Occidental and 19 in Kasaï Oriental.

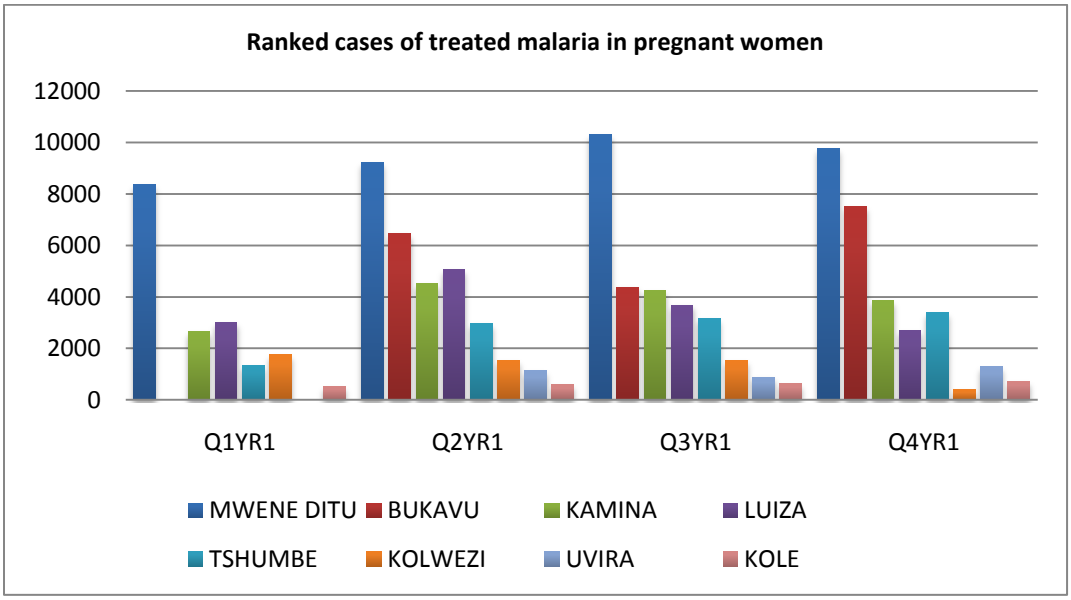
Table 11: Number of providers trained on prevention and case management of malaria

Kasaï Oriental/ Mwene Ditu				
No.	**Health Zone**	**M**	**F**	**Total**
1	Kalenda	52	2	54
2	Kamiji	27	0	27
3	Lusambo	23	4	27
4	Wikong	27	6	33
5	Luputa	46	14	60
6	Mpania Mutombo	20	2	22

7	Bibanga	28	6	34
8	Mpokolo	17	14	31
	Subtotal 1	240	48	288
Kasaï Occidental/Luiza				
No.	**Health Zone**	**M**	**F**	**Total**
1	Bilomba	14	0	14
2	Bulape	15	0	15
3	Dekese	19	0	19
4	Dibaya	16	1	17
5	Lubondaie	19	1	20
6	Kalomba	13	2	15
7	Ndekesha	16	2	18
8	Mutoto	15	0	15
9	Tshikaji	8	4	12
10	Yangala	27	2	29
	Subtotal 2	162	12	174
TOTAL		**402**	**60**	**462**

Distribution of IPTp and LLINs: The provision of an uninterrupted supply of Sulfadoxine Pyrimethamine (SP) for intermittent prevention treatment in pregnancy (IPTp) remains a challenge and stock outs are frequent. SPs are, like ACTs, RDTs, and LLINs, PMI commodities. Since the beginning of the DRC-IHP no SPs have been provided by PMI. The project awaits confirmation that a stock of SP will be delivered by December 2011. The number of pregnant women who received two doses of SP for IPT is about 19,382.

Figure 11: Number of pregnant women in IHP targeted health zones treated for malaria



IHP continued to distribute LLINs to pregnant women during their antenatal visits at the health facility level; these are provided by PMI in the 80 IHP health zones. Distribution figures for PY 1 are provided in Table 12.

Table 12: Distribution of LLINs in PY 1

PROVINCE	COORDINATION	Distribution of LLINs Q4Y1 (July-September 2011)			Distribution of LLINs PY1 (Octobre 2010-Septembre 2011)		
		# distributed in CPN	# distributed in CPS	Total # distributed	# distributed in CPN	# distributed in CPS	Total # distributed
Kasaï Occidental	Luiza	3,623	1,889	5,512	21,324	16,591	37,915
Kasaï Oriental	Mwene Ditu	19,029	5,350	24,379	78,335	27,684	106,019
	Tshumbe	1,634	1,512	3,146	19,323	25,304	44,627
	Kole	1,364	1,507	2,871	7,290	9,446	16,736
Katanga	Kamina	11,051	135	11,186	35,443	10,234	45,677
	Kolwezi	411	143	554	5,723	3,491	9,214
Sud Kivu	Bukavu	17,816	3,939	21,755	31,641	16,657	48,298
	Uvira	3,454	118	3,572	4,397	1,023	5,420
TOTAL		58,382	14,593	72,975	203,476	110,430	313,906

Distribution of ACTs, RDTs: Although approximately 2,500,000 ACTs treatments and 350,000 RDTs were distributed starting from Q2, in the fourth quarter IHP recorded a stock out of ACTs and RDTs in the health zones around Mwene Ditu. This situation is due to the fact that CADMEKO believed that it had mistakenly distributed IHP supplies of ACT and RDT to Global Fund-supported health zones in Kasaï Oriental. IHP used the Sankuru stock located in Kinshasa to supply health zones in Mwene Ditu that were experiencing stock outs. CADMEKO actively researched and recently found the IHP malaria supplies (ACT and RDT) that were reported missing. IHP is preparing a rapid distribution plan for the retrieved stock because a part of this supply will expire in April 2012. Given this experience with CADMEKO, IHP will tighten the technical support to and control system of all eight CDRs contracted by MSH. Table 13 reflects the shipments of ACT and RDT for Mwene Ditu and Tshumbe. Table 14 and Figure 12 provide data on the number of ACTs distributed by coordination area and by quarter for PY1.

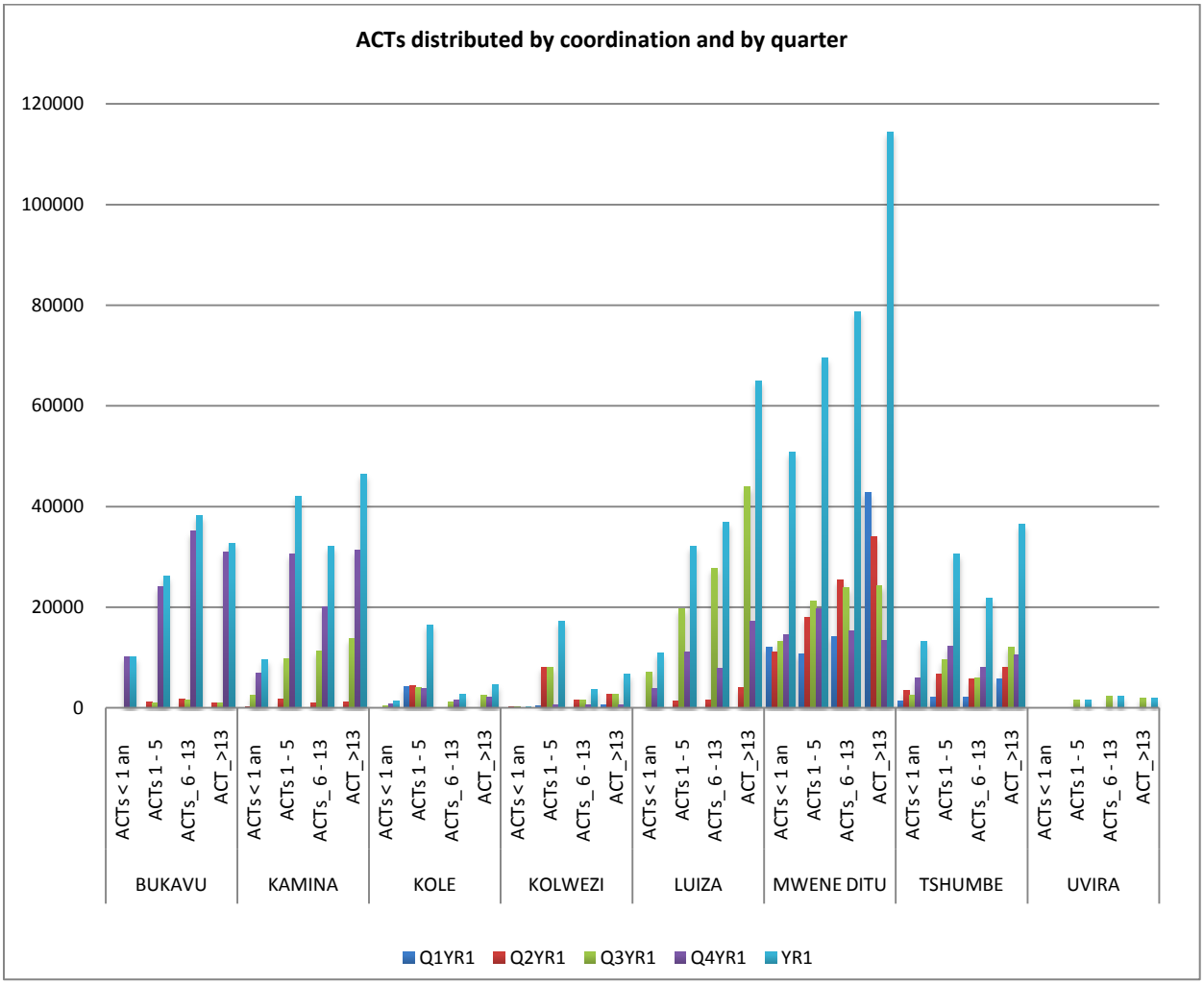
Table 13: Details of ACT and RDT shipments for Mwene Ditu and Tshumbe

N°	Items shipped	Tshumbe	Mwene Ditu	Total
1	ACT < 1 year	2000	4250	6250
2	ACT 1 to 5 years	100536	28864	129400
3	ACT 6 to 13 years	100798	26452	127250
4	ACT > 13 years	100640	44960	145600
5	Malaria RDT	26207	51668	77875

Table 14: Number of ACTs distributed by coordination and by quarter

		Quarter				
Coordination		Q1PY1	Q2PY1	Q3PY1	Q4PY1	PY1 Total
Bukavu	ACTs < 1 yr		0	0	10,139	10,139
	ACTs 1 – 5 yrs		1,100	960	24,057	26,117
	ACTs_ 6 – 13 yrs		1,670	1,460	35,043	38,173
	ACT_>13 yrs		890	945	30,906	32,741
Kamina	ACTs < 1 yr	0	149	2,505	6,962	9,616
	ACTs 1 – 5 yrs	0	1,767	9,720	30,575	42,062
	ACTs_ 6 – 13 yrs	0	958	11,193	20,006	32,157
	ACT_>13 yrs	0	1,184	13,805	31,354	46,343
Kole	ACTs < 1 yr	0	15	464	785	1,264
	ACTs 1 – 5 yrs	4,189	4,329	4,054	3,903	16,475
	ACTs_ 6 – 13 yrs	0	0	1,153	1,553	2,706
	ACT_>13 yrs	0	0	2,453	2,059	4,512
Kolwezi	ACTs < 1 yr	0	120	120	0	240
	ACTs 1 – 5 yrs	332	8,102	8,102	562	17,098
	ACTs_ 6 – 13 yrs	20	1,584	1,584	508	3,696
	ACT_>13 yrs	661	2,727	2,727	630	6,745
Luiza	ACTs < 1 yr	0	0	7,152	3,748	10,900
	ACTs 1 – 5 yrs	0	1,280	19,730	11,055	32,065
	ACTs_ 6 – 13 yrs	0	1,487	27,601	7,839	36,927
	ACT_>13 yrs	0	3,937	43,885	17,105	64,927
Mwene Ditu	ACTs < 1 yr	11,983	11,135	13,231	14,499	50,848
	ACTs 1 – 5 yrs	10,719	17,866	21,261	19,626	69,472
	ACTs_ 6 – 13 yrs	14,136	25,429	23,830	15,331	78,726
	ACT_>13 yrs	42,865	33,928	24,171	13,453	114,417
Tshumbe	ACTs < 1 yr	1,406	3,366	2,448	5,893	13,113
	ACTs 1 – 5 yrs	2,038	6,602	9,578	12,256	30,474
	ACTs_ 6 – 13 yrs	2,042	5,684	6,014	8,026	21,766
	ACT_>13 yrs	5,748	8,063	12,128	10,550	36,489
Uvira	ACTs < 1 yr		0	0	0	0
	ACTs 1 – 5 yrs		0	1,610	0	1,610
	ACTs_ 6 – 13 yrs		0	2,255	0	2,255
	ACT_>13 yrs		0	1,875	0	1,875
Total		**96,139**	**143,372**	**278,014**	**338,423**	**855,948**

Figure 12: Number of ACTs distributed by coordination and by quarter



Distribution of severe malaria treatment kits: The first shipment of severe malaria treatment kits/commodities for the four provinces, which were procured with FY09 funds (former AXxes Project), finally arrived in country; however, they are still waiting customs clearance before they can be distributed. In DRC, quinine is among the drugs the MOH banned for importation. An application for a waiver is being processed, since the kits contain quinine sulfate (tabs), quinine di-Hcl (injectables), dextrose 5% (bottle of 500ml, 250ml, infusion set, IV cannulae 18/22/24G), latex examination gloves, disposables syringes, and Sulfadoxine/Pyrimethanime (tabs). With USAID's support, discussions are now taking place to address the issue of banned drugs for importation.

Distribution of microscopes and reagents kits for the laboratory diagnosis of malaria: During the fourth quarter, PMI provided IHP with microscope and reagent kits for laboratory diagnosis of malaria at the hospital level, which were distributed according to a plan established in collaboration with the respective provincial representative of the NMCP. See Table 15 for details.

Table 15: Distribution plan and status of microscope and reagent kits

N	Destination / IHP coordination office	Quantity	Remarks
1	Kananga /Coordination Luiza	10	Delivered
2	Lubumbashi/ Coordination Kolwezi	5	Delivered
3	Lubumbashi / Coordination Kamina	5	Delivered
4	Bukavu / Coordination Bukavu	8	Delivered
5	Bukavu / Coordination Uvira	2	Delivered
6	Kinshasa / Coordination Kole	2	Stock still in Kinshasa
7	Kinshasa / Coordination Tshumbe	3	Stock still in Kinshasa
8	Mbuyi Mayi /Coordination Mwene Ditu	5	Delivered
	Total	**40**	

Provide technical, logistical and financial support to health zones during LLINs campaign: IHP participated in the launch ceremony for the mass distribution of LLINs in Kasaï Occidental and is monitoring the distribution of these nets on an ongoing basis in project-supported health zones.

Supervisory visits: Support and implement effective supportive field supervision and mentoring of malaria component: The IHP Malaria Advisor participated in PMI tracking visits (for ACT and RDT) in the two Kasaï provinces, looking at both regional and health zone distribution. Data quality audits (DQA) were conducted in two health zones in the Luiza Coordination.

Activity 20: Nutrition rehabilitation

IHP implemented a nutrition activity inventory at all IHP coordination areas. The inventory reviews the technical and operational capabilities of IHP coordination areas and their corresponding health zones, to better develop customized and appropriate approaches and strategies, identify gaps and priority needs, and plan for activities in year 2 of the project. This inventory analyzed health zone needs with respect to essential nutrition actions, treatment of acute malnutrition, mapped the different partners who work in nutrition, and the material needs for treatment (vitamin A, folic acid, Mebendazole, Ready-to-use Therapeutic Food [RUTF], etc.).

The inventory included the following items:

- Identifying information for the health facility
- Status of capacity building/training reinforcement in nutrition for each facility with respect to essential actions in nutrition, integrated treatment of acute malnutrition, and nutritional oversight (routine, national system of nutritional oversight and early alert). Each health zone indicated ("yes" or "no" whether service providers were trained in these areas.
- Number of existing and functional nutritional units
- Availability of prescriptive documents such as the National Health Development Plan Nutrition component 2011-2015; the protocol for integrated treatment of malnutrition; Essential Nutrition Action (ENA) modules; nutrition activity management; key ENA messages; monthly summary forms of nutrition data, etc.
- Inventory and equipment/material needs
- NGO support in nutrition and areas/packages.
- Estimate of input needs by month: vitamin A 100,000 IU (child 0-11 months), vitamin A 200,000 IU (nursing women), folic acid (pregnant and nursing women).

In August, the IHP nutrition advisor traveled to the Sankuru Health District to meet with members of the health district management teams to define areas of collaboration in the context of IHP's nutritional

support in the health zones. He carried out site visits with service providers across the Ototo and Lodja zones to assess the operational and technical capacity in select health centers (Shele, Tshodi, Okitandeke, and the Franciscan Maternity health center in Lodja).

In addition, IHP held a meeting to establish collaboration between Catholic Relief Services (CRS) in Lodja and IHP. CRS supports treatment of malnutrition cases (in collaboration with Caritas Tshumbe) in four approved health zones that are also supported by IHP, including Vangakete, Omedjadi, Lodja, and Lomela. The meeting resulted in an outline of collaborative activities including: quarterly meetings, information and knowledge exchange, and streamlining interventions in the shared health zones.

To further collaboration with MOH and other partners in nutrition activities, IHP initiated introductory meetings to present the project and propose future joint activities. These took place with PRONANUT (national nutrition program), the directorate responsible for infant, child, maternal and specific group health (D10), and Action Against Hunger. All partners agreed to exchange information, especially in shared health zones to establish an effective system of coordination and prevent duplication of services.

IHP provided technical, logistical, and financial support to write and validate a health card for children ages 0 to 5, introduced by the MOH with the collaboration of other MOH support partners. In addition, two IHP Technical Specialists from the Tshumbe and Kamina coordination areas participated in the emergency nutrition training held by UNICEF and PRONANUT in Kinshasa and in Lubumbashi.

Activity 51: PMTCT

The revision of PMTCT tools planned in September 2011 did not take place as scheduled because most of the USAID and CDC partners were focused on the planning process for the next fiscal year. In addition, the PNLS team was conducting the UNICEF supported situation analysis and the preparations for the Global Fund round 11.

During the fourth quarter, IHP organized integrated HIV training in two coordination areas, Mwene Ditu and Kamina. Overall, IHP trained 134 service providers, including 74 in Mwene Ditu and 60 in Kamina. The training focused on how to understand, analyze, and improve the following elements:

- Conduct comprehensive VCT, provider-initiated counseling and testing (PICT) and PMTCT counseling
- Classify patients using the WHO classification system[2] for improved clinical management
- Enable doctors, in particular, to prescribe and administer ARVs using the national protocol
- Monitor HIV + pregnant women on ARV/Cotrimoxazole preventive therapy
- Monitor HIV + mothers and infants exposed to HIV
- Take proper blood samples from infants exposed to HIV for early diagnosis
- Treat opportunistic infections using established algorithms
- Treat sexually transmitted diseases using the syndromic approach with algorithms
- Monitor patients on ARVs (clinical and biological monitoring)
- Support people infected and those who are affected by HIV
- Rationally manage all HIV control commodities
- Use rapid tests in connection with HIV screening based on algorithms recommended by PNLS
- Organize, monitor, and supervise HIV/AIDS control activities
- Prepare and transmit the monthly activity report to the Kinshasa office.

[2] http://www.who.int/hiv/pub/vct/hivstaging/en/index.html

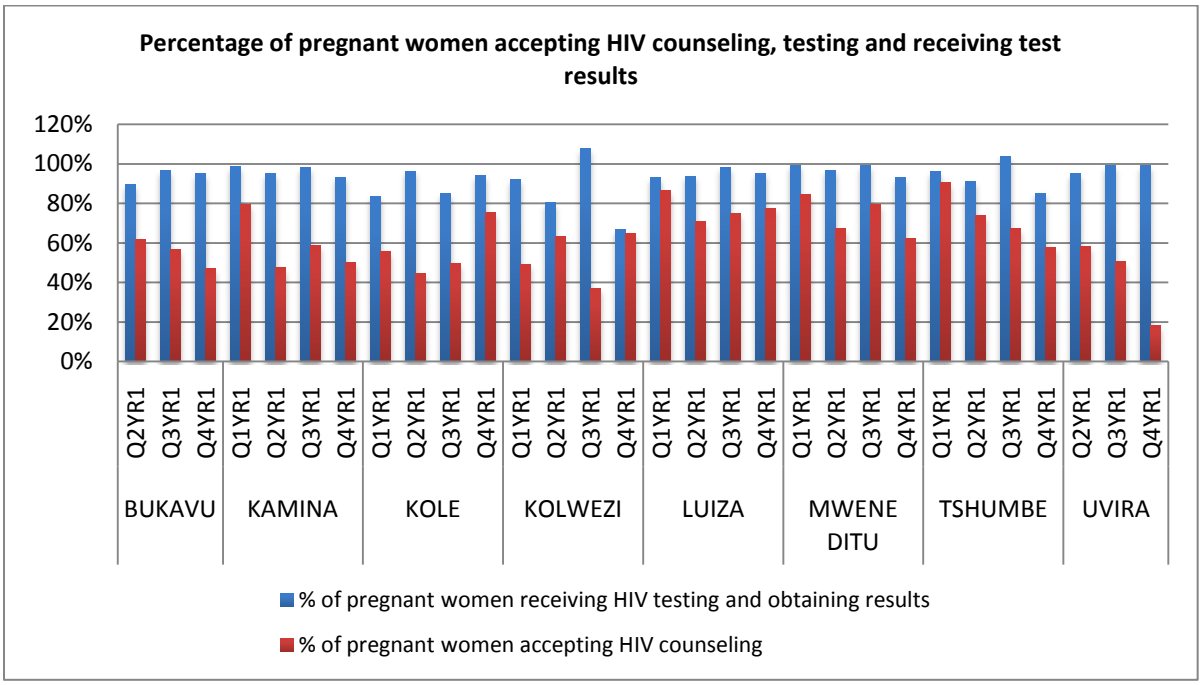
Although the training was also planned for Kolwezi, trainers and providers were unavailable, primarily due to the vaccination campaigns. This training session will take place in the first quarter of PY2.

Although a major challenge during this reporting period was the lack of PMTCT commodities available in all 138 PMTCT sites, IHP was able to borrow some rapid tests from ProVIC and use them in some of the sites, and locally-purchased tests also helped contribute to the PMTCT results presented in this report.

During the last half of the quarter, IHP actively participated in planning and finalizing the PEPFAR 2012 Country Operation Plan (COP). IHP also provided technical assistance to the PNLS to identify the package of interventions and develop the country indicators to eliminate HIV by 2015 during preliminary work for round 11 of the Global Fund through the PMTCT working group. As part of this process, IHP provided information on the health zones supported by the project.

IHP visited Bukavu and Uvira in July to evaluate the PMTCT sites and monitor activities related to tuberculosis at the intermediate and peripheral levels. IHP recommendations related to PMTCT included the immediate need to get the necessary commodities in place to support PMTCT services and strengthen service providers' capacity in the new PMTCT protocol and early diagnosis. The planned visit to Kananga was postponed to PY2 following revisions to the terms of reference for the activity.

Figure 13: Percentage of pregnant women accepting HIV counseling, testing and receiving test results



Blood Safety: In the fourth quarter, 30,000 bags of blood were supplied to health zones the Bukavu and Uvira coordination areas. The other coordination areas are sufficiently stocked until the end of January 2012 (Kolwezi and Kamina offices) and the end of June 2012 (Luiza, Mwene Ditu, Tshumbe, and Kole offices). IHP trained 79 out of a planned 80 peer recruiters during this period (49 in Bukavu and 30 in Uvira). Peer recruiters are blood donation volunteers who conduct community mobilization activities to motivate other community members to voluntarily donate blood to save lives and to increase the

number of peer recruiters. The training session for service providers on blood transfusion in hospital settings, planned in collaboration with Save Blood for Africa, was postponed to PY2.

Activity 52: Tuberculosis

IHP provided technical support to the Bukavu coordination office and the provincial tuberculosis control coordination office (CPLT) to prepare the framework for the TB situation analysis. In the Kamina coordination area, this activity was postponed until the next fiscal year due to the volume of other planned activities. The preliminary results of the situation analysis and the data audit in the nine health zones visited include the following findings:

- The health centers for diagnosis and treatment of TB (CSDT) had a stock out for approximately 110 days of anti-tuberculosis medications (the Minova health zone had to go to Goma for its supply of anti-tuberculosis medications)
- The co-infection sites had a stock outs of reagents, which made it difficult for them to function; sites operated by purchasing tests with their own funds or borrowing tests from PMTCT services where they were available
- The diagnosis of MDR cases does not take place in any CSDT, due to a lack of capacity, because service providers are not yet trained in MDR
- There is low involvement of community health workers in the community DOT due to the lack of incentives
- The detection rate remains low (± 15%) in the 9 health zones visited
- Coverage of CSDT and health centers for treatment of TB (CST) is low in the health zones visited, thus the need for a CSDT extension plan and to create other CST to improve geographic accessibility
- There is a lack of report archiving at the BCZ level
- Service providers who are not trained in the Integrated Anti-Tuberculosis Program (PATI) in certain CSDTs are treating tuberculosis.

The PATI-4 training modules serve as a reference for providers. They are being produced in Kinshasa and will be distributed at the peripheral level (ECZSs, HGRs, health centers, particularly CSDTs and CSTs) and at the intermediate level, particularly to the health districts. For health centers that are not yet CSDTs or CSTs, the distribution of guides will be preceded by activities to strengthen service provides' capacities.

At the end of Q4, there is a clear need for inputs and laboratory reagents for TB diagnosis. IHP anticipates ordering additional laboratory commodities, particularly receptacles and blades, which are in short supply in almost all health zones and provincial tuberculosis coordination offices (CPLT).

Since no MDR TB cases have been diagnosed in the project intervention zones, IHP is addressing whether or not service providers are able to make a valid diagnosis. The project anticipates planning sequential training in MDR-TB in the health zones to address this issue.

IR 2.2 Minimum quality standards for health facilities (provincial hospitals and zonal health centers) and services adopted

Activity 1: Scale up a whole-site standards-based quality improvement approach at target facilities (FOSACOF)

IHP held training sessions on FOSACOF in Bukavu for representatives in both Bukavu and Uvira. The first training was a TOT with participation of a total of 32 persons, including six IHP staff and representatives of the provincial and district health management teams. The capacity building specialists from Mwene Ditu, Kole, Kamina, and the Kinshasa-based capacity building advisor conducted the sessions. Subsequently, the provincial and district health management teams who had been trained as trainers led the training for members of the ECZS (five zones in Uvira and six in Bukavu), supervised by the IHP capacity building team.

In addition, the project identified FOSACOF sites and trained service providers by coupling these activities with others undertaken by provincial health division in all five health zones. These activities are planned in Kolwezi for PY2.

Activity 2: Design and implement a PBF program

Quarter 4 PBF activities related to writing the procedures manual and program management tools, preparing for the training and implementation of PBF in the structures, and supporting the MOH to write their PBF training manuals.

1.1. Main activities associated with writing procedure manuals

The IHP PBF team presented the IHP PBF procedures manual to IHP staff for their review and input during a workshop organized for that purpose. The manual and management tools were then presented to the MOH PBF Unit, as well as the USAID health team, who appreciated the work done to date and provided relevant and substantial contributions for improvement. After these activities were completed, the feedback was integrated into the PBF model and management tools.

1.2. Activities to prepare and implement PBF in the health zones

Identifying PBF targets consisted of determining health zone target populations and identifying targets for each indicator. Setting these targets in the coordination offices was the first phase of determining annual and quarterly targets to be negotiated in work plans. IHP BCC specialists in the coordination offices and advisors in Kinshasa worked together to elaborate indicators to be considered in assessing the performance of community-based organizations. The latter will play a major role in conducting counter-verification in the community of the results health centers report prior to payment for results.

1.3. Support for writing MOH training manuals

IHP organized a workshop to support the development of the MOH training manuals, during which they analyzed PBF manuals from different projects. This activity provided a stronger foundation for the DRC national PBF training and training reference documents.

During implementation of the above activities, IHP noted several main challenges to be overcome during the implementation of the PBF program:

- External challenges
  - *The MOH has little experience with PBF:* Given the important role the MOH plays, IHP is addressing this challenge by taking the lead on technical support/building capacity for the national PBF cell. This support will continue in PY2.
  - *The existence of several approaches and of several PBF partners in cou*ntry: This challenge has resulted in strategic positioning conflicts which IHP is addressing.

- The main internal challenge is essentially the availability of staff to implement the PBF. This required solicitation for additional technical managers.

IHP organized a TOT in Kinshasa on PBF, with the participation of representatives from the coordination offices. Each coordination office identified one health zone for PBF activity. These health zones were selected based on common criteria that will be used across all IHP areas (security context, indicators, presence of other partners). Each IHP office also selected a "back up" health zone in the event that their first choice was not considered suitable by the IHP central office. In the fourth quarter, baseline information on the health zones selected to implement the PBF program was collected in Uvira and was transmitted for analysis to the IHP technical team in Kinshasa.

IR 2.3 Referral system for primary health care prevention, care and treatment between community structures and health facilities (provincial and zonal levels) institutionalized

Activity 1: Work with CODESAs to strengthen two-way community-facility referral networks
This activity is planned for the first quarter of year two.

Activity 2: Scale up referral for victims of sexual assault
During the fourth quarter, in Uvira's Nundu health zone, OCHA reported widespread acts of rape of women in the fields in the Kaboke II health area. Following recommendations made by the IHP team to the ECZ in the previous quarter (to inform communities of the availability of clinical care for sexual assault victims, including those needing fistula repair due to trauma), the local NGO AFED referred six of the survivors to the GRH in Panzi.

Activity 3: Extend support for fistula victims
During the fourth quarter IHP supported fistula care in the general reference hospital of Kaziba, where 20 obstetrical fistula clients were successfully treated.

Activity 4: Reinforce the reference system for CMD family planning clients to obtain family planning methods in health facilities in the 80 health zones
During joint supervisory visits with the ECZ, IHP teams helped service providers to promote the use of family planning services and the use of community outreach workers (*relais communautaires*) to increase community awareness of the different modern contraceptive methods. Training of service providers on the new methods and technologies is planned for PY1Q1.

Activity 5: Reinforce the monitoring and supervision of head nurse of the health center in activities in the 80 health zones
All of the ECZs received financial support from IHP for supervisions in health facilities to reinforce the capacities of service providers. However, after finding that data collection tools for ECZs visits were missing, IHP worked with ECZS to produce a supervision template. In addition, the IPH team has identified several areas for improvement by the ECZS, including:

- Distribute LLINs to the correct target groups (pregnant women)
- Ensure consistent monitoring of indicators and coherence between the numbers reported and those recorded in health centers
- Ensure sufficient hygiene during deliveries and poor post-natal follow up
- Improve hygiene in general in the hospitals

Activities to address these issues were added to a remedial plan developed between IHP, ECZ staff, and health center staff, with responsibilities attributed to each party. In the fourth quarter, the Hauts Plateaux health zone in Uvira was not supervised due to an unstable security situation.

Intermediate Result 3: Knowledge, attitudes, and practices (KAP) to support health-seeking behaviors increased in target health zones

For this reporting period, the IHP team completed the following activities under IR 3:

- BCC specialists, community mobilizers, and national and provincial representatives of the Ministry of Health were trained in BCC and ETL techniques
- BCC and ETL training tools and reference manuals were developed for IHP staff
- Synergies for cooperation and sharing of KAP research data with strategic partners were identified
- An overarching IHP BCC strategy document with BCC campaign sequence was developed in close collaboration with the MOH and strategic partner representatives
- The team collaborated with C-Change and the MOH to plan for IHP's first BCC campaign on malaria in December 2011
- An SMS pilot was implemented in two health zones

In addition, IHP community mobilizers and BCC specialists assessed the functionality of CODESAs in identified health zones, as well as provided training to CODESAs.

IR 3.1 Evidence-based health sector-community outreach linkages – especially for women, youth and vulnerable populations – established

Activity 1: Conduct baseline KAP assessments for IHP target zones
Based on numerous meetings with strategic partners and discussions during the strategic communications workshop held from July 25-30, 2011, the BCC team recommended that additional complementary KAP/qualitative studies be specifically conducted for FP and immunization. IHP will collaborate with the respective MOH programs and directions and partners such as C-Change and PSI/ASF who have agreed to share their recent KAP data in the other IHP health domains to inform upcoming IHP BCC campaigns.

Activity 2: Establish local NGO coordination mechanism at the province level
In Sud Kivu, NGO coordination meetings are held at the provincial level weekly. The IHP Uvira office participates in the health cluster meetings regularly, in addition to WASH, Nutrition, and HIV clusters. In Kolwezi, participation in coordination meetings at the provincial level is difficult due to the distance between Kolwezi and the provincial capital.

Activity 3: Pilot implementation of Education through Listening Approach (ETL)
This activity is planned for PY2, but preparatory work this reporting period included training 21 IHP staff and MOH representatives in BCC and ETL techniques and methodologies. Training and reference materials were developed for this five-day training, which was held July 4 to 8, 2011. Participants included five IHP BCC specialists, seven community mobilization specialists, six MOH provincial level representatives (community agent, provincial health communication coordinators), and three MOH

central level representatives (11th Direction for Capacity Building, 5th Direction for Community Participation, and the General Secretary office of the MOH).

The goal of the training was to improve participants' knowledge of evidence-based BCC methodologies and build capacity to develop, implement, monitor, and evaluate effective, non-didactic BCC strategies for health. Test scores of participants more than doubled at the post-test. OSC BCC Consultant Amélie Sow-Dia trained participants in the Johns Hopkins University P-Process methodology for strategic communication design and planning and used a combination of ETL and VIPP (Visualization in Participatory Programs) compatible with adult learning principles to facilitate the workshop. MOH central level officials participated fully and expressed appreciation for the invitation, IHP's collaborative approach, and the training methodology and content. Key participants included Dr. Lina Piripiri, alternate AOTR for IHP, who came to the ETL session; Dr. Ferdinand Ntoya, C-Change Malaria Program Manager, who shared experiences on communication material pretesting; and Dr. Salva Mulongo, Community Mobilization Specialist, who facilitated the session on community mobilization and champion communities.

In September, consultant Amélie Sow-Dia developed a BCC reference manual for workshop participants and an ETL reference guide and ETL training manual for the planned ETL TOT that will take place in October 2011, which will build the capacity of OSC/IHP BCC specialists, IHP community mobilization specialists, and national and provincial MOH representatives to train community members in this participative IPC approach.

IR 3.2 Health advocacy and community mobilization organizations strengthened

Activity 1: Assess/improve CODESA's existence and functionality

This quarter, IHP's field-based BCC specialists and community mobilization specialists assessed and revitalized 904 CODESAs out of a total of 1,428; additional CODESA were also assessed for future strengthening. CODESAs are considered functional when they conduct meetings, community activities and provide reports. They are considered revitalized when, in addition to being functional, the representation of women (at least 30%) and youth (at least 30%) among members is achieved. The table below shows results attained during the reporting quarter.

Table 16: Number of CODESAs assessed, revitalized, and functioning

Field office	# CODESA	# CODESA Revitalized and functioning	# CODESA to assess and revitalize	% achieved	Observations
KOLE	55	**37**	18	**67**	Difficulties accessing Lomela et Bena Dibele (AS riveraines)
Mwene Ditu	194	**194**	0	**100**	
Tshumbe	169	**79**	90	**46**	3 health zones (Lodja, Omedjadi and Vanga Kete) with 57 AS were recently assigned to this field office
Luiza	192	**151**	41	**78**	In progress
Kamina	201	**180**	21	**89**	In progress
Kolwezi	106	**51**	55	**48**	BCC Specialist being deployed
Uvira	103	**64**	39	**62**	In progress
Bukavu	408	**148**	260	**36**	In progress
TOTAL	**1428**	**904**	**524**	**63**	**Figures to be reviewed**

The assessment revealed that in Kolwezi, 55 of the 106 CODESA have serious operational problems and are in need of revitalization. The situation was the same in Bukavu, where a revitalization plan is currently being implemented by IHP staff, which completed visits to 271 CODESA. The plan consists of ensuring open election of CODESA members, official establishment of the CODESA by ensuring their certification by the local authorities, training members, developing local action plans, and conducting monitoring visits. In Uvira, 103 of the 104 health areas are covered by a CODESA, with the exception of Makobola, due to an ongoing conflict between the BCZS and the local authorities (the local chief had nominated the CODESA instead of allowing elections). The number of health areas in Uvira has increased from 102 to 104 during the final quarter of PY1, after the decision of Lemera health zone to promote two health posts to health centers (Busulira and Bulaga) due to geographic inaccessibility (long distances and mountainous area). The assessment revealed that 63 of the 104 identified CODESAs need to be re-established.

IR 3.3 Behavior change campaigns involving opinion leaders and cultural influences (people and technologies) launched

For this reporting period, IHP, in collaboration with partners, BCC Specialists, community mobilizers, and national and provincial representatives of the Ministry of Health, identified channels for communication in the health zones, carried out community awareness sessions on selected topics, and drafted the IHP BCC strategy, among other activities.

Activity 1: Select and train community champions
This activity has been scheduled for year two.

Activity 2: Conduct a rapid assessment of health communications capacity in health zones
Activities began in this quarter to identify the various communication channels available in each health zone that will help inform future strategy in this area.

Activity 3: Design and implement health communications campaigns
In Bukavu, IHP community mobilizers assisted ECZ to carry out community awareness sessions on several key health practices, such as hand washing with soap, using clean drinking water, and how to correctly use LLIN. In Shabunda, one IHP community mobilizer partnered with the zonal rural development technician to present information on the correct use of mosquito nets during a local radio broadcast.

Overarching draft IHP BCC Strategy for PY2-5 developed in consultative process with key MOH programs, directions and strategic partners: A significant achievement during this reporting period was the development of an overarching IHP BCC strategy document with BCC campaign sequencing.

The strategy workshop, held July 25-30, included a total of 30 representatives of a host of Ministry of Health (MOH) Programs and Direction representatives and strategic partners[3], as well as journalists, community theatre actors and artists, resulted in an integrated, overarching draft IHP *Tuendeni-*

[3] Workshop participants included representatives of the National Program against diarrhea, 10th Direction, National Nutrition Program, National Malaria Program, National TB Control Program, National anti-TB league, National Health Communication Program, National Reproductive Health Program, MCHIP, C-Change, UNFPA, ProVIC, PSI/ASF, SANRU, SFCG, IRC, JSI, Action Against Hunger, Development and Training Services, and the FemmesPlus HIV Hotline. The MOH and all partners met and involved in this process attested to their satisfaction with IHP's approach to partnership and its genuine attempt to involve all stakeholders.

Kumpala[4] BCC strategy for PY2-5 which was adopted by consensus by all participants. The draft Tuendeni-Kumpala BCC strategy includes:

- IHP's vision for family health in Congolese households, the goal and objectives of the BCC strategy
- Key behavioral problems for each of the IHP health domains
- A description of primary and secondary audiences per health domain
- Communications objectives per key audience and health domain
- Positioning guidance including a proposed slogan: "*My family's health first!*"
- A proposed sequence of the various BCC campaigns for the next 4 years
- Message briefs for all health domains and strategic communication approaches
- Branding guidance. All individual campaigns under the strategy will be implemented under the same slogan, logo, call to action and color scheme.

Participants recommended that a Tuendeni-Kumpala BCC Strategy Steering Committee will be established to oversee implementation and evaluation of the strategy. MOH 5th Direction offered to take leadership in convening the Steering Committee, which will include all key MOH directions and IHP strategic partners.

Draft MOU to formalize IHP-C-Change partnership developed: OSC Senior BCC Expert and OSC BCC Consultant Sow-Dia held a series of meetings/working sessions with C-Change and developed a draft MOU to formalize the working relationship with C-Change. The MOU establishes a framework for collaboration to ensure smooth implementation of respective IHP and C-Change BCC activities at national and provincial level. The MOU has the following objectives:

- Identify areas for collaboration between the two organizations as part of a successful partnership.
- Determine the roles and responsibilities IHP and C-Change in the implementation of communication activities in the provinces of IHP/USAID intervention.

IHP/C-Change draft action plan for the "3+1 Campaign" against malaria developed: As a result of OSC/IHP Senior BCC Expert Mputu Mamba initiating several working sessions with C-Change to discuss and plan activities for the "3+1 Campaign" against malaria, a shared draft action plan has been developed that includes a supervision and M&E component. IHP and C-Change will be partnering on this upcoming campaign, which will take place from December through April in the provinces of Katanga and Sud Kivu. C-Change and IHP agreed to harmonize campaign activities and community mobilization approaches in overlapping health zones, and work together to optimize resources for improved results. IHP will initiate multi-media community-based BCC campaigns on malaria in Katanga, Sud Kivu and in the two Kasaï Provinces as outlined in the Tuendeni-Kumpala BCC Strategy. C-Change will conduct community mobilization through the community component of its malaria program in five health zones in Katanga and 5 in Sud Kivu.

Activity 4: Conduct earned media campaigns

This activity is scheduled to begin in October 2011.

Activity 5: Pilot phone-based information campaigns

[4] *Tuendeni* in Swahili and *Kumpala* in Tshiluba both mean let's hold hands and move forward together.

Literature review on mobile phone-based interventions and SMS pre-pilot in two health zones concluded: The OSC consultant conducted a literature review on mobile phone-based interventions and met with strategic partners (ProVIC, TB2015, PSI/ASF, C-Change, FemmesPlus) and IHP technical staff to evaluate the landscape in DRC for mobile phone and phone-based communications to support IHP BCC campaigns. Recommendations included the need for further research to test and develop the SMS pilot concept and PBx pilot concept.

OSC/IHP Mobile Technology Expert Paul Neely worked with IHP to develop SMS messages for the implementation of an SMS pre-pilot in two health zones in Kasaï Occidental (in the Luiza field office – Tshikaji and Luiza). The SMS pre-pilot clearly demonstrated the effectiveness of SMS in reaching large audiences with health information and Congolese target audience receptiveness to SMS as a supplementary communications channel for BCC provided a few technical challenges related to bulk SMS transmission are addressed in the scaled up campaign design.

To contribute to the upcoming IHP malaria BCC campaign, the SMS pre-pilot consisted of two SMS messages on malaria, in French and Tshiluba, sent through free FrontlineSMS software and using only a laptop and modem. With the help from community health workers (RECOs) approximately 285 community members (including women, men, youth, community leaders and health workers) were recruited to voluntarily participate in the pilot. SMS messages were sent to the telephone numbers collected within a 500km reach of the city of Kananga. Target audience receptiveness to SMS and its effectiveness in disseminating health messages were tested in focus groups of a total of 169 participants in 6 separate rural, peri-rural, and urban communities, in personal interviews, questionnaires and group feedback sessions. Some key lessons learned:

- Of the communities participating in the small pilot, more than 50% own or have access to a mobile phone (of which 18% are women).
- The more rural the location, the more interested and responsive are the recipients.
- A large majority of recipients in all locations assessed SMS health campaigns as 'very effective'.
- SMS made recipients feel empowered and less dependent to seek out health information.
- SMS boosted community dialogue on health.
- Health worker recipients are very positive about an SMS campaign that supports them in their activities in the community.
- Training in SMS is required for a small percentage of recipients.
- There is a preference for receiving messages several times a day or week during a campaign.
- There is a preference for receiving short messages in the local language.
- Some indicated that they wanted to be able to ask and have someone respond to their questions.
- Poor coverage, especially in rural areas, remains a challenge as well and access to mobile phones could limit campaigns targeting more specific audiences, such as abused women.
- Bulk SMS messaging should be done through mobile phone service provider websites or service provider servers, both of which are possible. Mid-size campaigns can be carried out with a laptop and modem, if transmitting from Kinshasa.

OSC/IHP Mobile Technology Expert Neely facilitated initial meetings with Vodacom and Airtel which showed potential for partnership in an SMS and, at a later stage, phone-based exchange (PBx) pilot. OSC/IHP Senior BCC Expert Mputu Mamba and Mobile Technology Expert Neely met with MOH officials and strategic partners on IHP's mobile phone-base/SMS approach. These included officials from the

MOH National Malaria Program, which was very responsive and interested in using SMS in public outreach and education; PSI/ASF and FemmesPlus on their respective hotlines on FP and HIV/AIDS and GBV (*ligne verte*); ProVIC, which worked with mobile operator Tigo on a mass SMS campaign on HIV/AIDS and is currently in contact with independent firm Okapi that provides access to a database of clients; and PATH, which is planning to use a phone system offered by Airtel to enable them to work with a type of PBx system.

Health communications capacity in health zones assessed: The OSC/IHP media specialist assessed online and in-person health zone communications capacity by meeting with Radio France International, Internews, Panos Institute, Radio Okapi, and several other organizations involved in supporting Congolese media. He also identified existing provincial media networks with the potential for IHP collaboration. He also concluded preparations for the two media workshops in October for IHP field-based staff, MOH representatives and provincial and local journalists. These workshops will result in improved media understanding and skills of participants, local media awareness and buy-in of IHP objectives and activities, and the development of provincial earned media plans as integral components of the Tuendeni-Kumpala BCC Strategy.

Major findings and recommendations for Quarter 4 and PY1:

- OSC Senior BCC Expert, BCC Specialists and Community Mobilization Specialists, in collaboration with provincial MOH authorities, succeeded in assessing and revitalizing 904 out of a total of 1428 CODESAs (63% of all CODESAs). While all field offices are on track, the field office in Mwene Ditu earns a specific mention, having succeeded in assessing and revitalizing all 194 CODESAs, i.e. a 100% completion result.
- At the start of PY2, OSC/IHP is well positioned for a rapid scale up of regional communications capacity mapping and outreach, assessment and revitalization of the remaining 524 CODESAs, and the implementation of the Tuendeni-Kumpala BCC Strategy per field office. With a scheduled regional TOT in ETL and planned cascade training starting in the 1st quarter of PY2, 2 regional media workshops for field staff, local journalists and MOH representatives, and the deployment of a Community Champion Consultant in October to develop the IHP Community Champion approach, manual and implementation tools, the platform at the start of PY2 is set to incrementally start launching other activities that require substantial groundwork such as:
    - IHP's first BCC campaign on malaria in December
    - Implementation of the Community Champion pilot in eight health zones
    - Holding regional journalist training, site visits and implementation of provincial earned media plans
    - Holding local NGO coordination meetings and assisting CODESAs and NGOs in the development of local health communication action plans
    - Development and implementation of SMS and PBx pilots in 16 and eight health zones, respectively.
- The work of OSC/IHP Senior BCC Expert Mputu Mamba and STTA deployment over the course of PY1 has resulted in: rapid assessments of existing (KAP) data and communications capacity; building the BCC/ETL capacity and skills of IHP staff and representatives from the national and provincial MOH; deepening the partnership between IHP and key MOH programs and directions as well as collaboration with strategic partners and NGOs; testing the potential of mobile phone-based interventions to supplement BCC campaigns; and the development of an overarching, integrated and collaborative IHP Tuendeni-Kumpala BCC strategy document that will guide project BCC activities going forward over the next four years.

- The draft Tuendeni-Kumpala BCC Strategy will be circulated among the IHP technical team, COP and the Tuendeni-Kumpala Steering Committee for feedback and comments and, after full integration of all comments, will be submitted for validation in the next reporting period.

I.2 COMPONENT 2: HEALTH SYSTEMS STRENGTHENING

Intermediate Result 4: Health sector leadership and governance in target provinces improved

IR 4.1 Provincial health sector policies and national level policies aligned

Activity 1: Support the implementation of national and provincial health policies
The process of workplan harmonization gives IHP the opportunity to promote the MOH's Annual Operational Planning (AOP, or PAO, in French) and alignment of its partners to the Medium-Term Expenditure Framework (MTEF). IHP provided financial and technical support to the workshops carried out in the four IHP-supported provinces supported.

Activity 2: Support the Ministry of Public Health in the revision, dissemination, and extension of norms and policies at the national and provincial levels
In Kolwezi, during the FOSACOF training of trainers, IHP distributed manuals on MOH Health Zone Standards, the revised version of the MOH's Strategy for Reinforcement of the Health System, trainers guides on clinical flow charts, and the MOH list of essential generic medicines.

Activity 3: Support the provincial and district levels with the implementation of policy (norms, protocols, and tools) adapted to the local context in each province
In collaboration with other partners, IHP provided financial and technical support to the MOH to revise and further develop IMCI policy documents related to norms, protocols, and tools, and to finalize the training tool that is used to orient trainers in charge of training providers on utilization of the flowcharts (*ordinogrammes*) documents at health facility level.

Activity 4: Advocate for policies specifically focusing on the health of women to ensure they are implemented
The IHP Gender Advisor joined the project in August 2011; to date, she has designed a gender strategic plan including advocacy activities that will be high priority in the IHP PY2 workplan.

Activity 5: Support the health zones to write a health development plan (strategic plan) and an operational plan that align with MOH health policies, which will be provided to the participants
The DPS completed this activity in the first quarter of 2011 with support from other partners. IHP has supported the ECZ in the evaluation of progress according to these plans. The Kolwezi's health zones plans were not officially validated by their respective Boards of Directors, although implementation began. IHP worked with ECZ to lay out plans to support the health zones in completing their annual reports and develop operational plans for 2012.

IR 4.2 Evidence-based tools for strategic planning and management decision-making adopted

Activity 1: Support the health zones to write a health development plan (strategic plan) and an operational plan that aligns with health policies the development plan for reference hospitals is included in the health zone development plan

See IR 4.1 Activity 5.

Activity 2: Provide health zones with the resources (tools and policies) for the development plan and operational plan (the operational plan for reference hospitals is included in the operational plan of the health zones)
IHP plans to provide technical and financial support to health zones to design their PAO 2012, which will include general reference hospitals.

Activity 3: Conduct an assessment of the current status of HMIS (people trained and level of implementation) and computer kits in the Health Zone, Provincial, and Health District levels
The assessment of the current status of HMIS was carried out in the previous quarter. Health zone assessments were completed in Uvira also evaluated the presence and functionality of computer kits at the health zone level. As mentioned earlier, these kits were found to be functional.

Activity 4: Train the Provincial and District Management Teams in management systems for health (human resource, financing, etc)
No activities took place during this reporting period.

Activity 5: Provide the health zones with management tools
IHP provided the SNIS reporting tools to targeted health zones. In PY2, IHP coordination offices will be equipped to respond to health zones' needs related to management tools in a more cost-efficient and rapid way.

Activity 6: Install the GESIS software and train data managers in the provinces, health districts, and health zones in the collection, compilation, analysis and use of the data
IHP supported a joint field visit with the MOH and SPS to assess the needs and priority areas to be considered during IHP PY2, and these needs have been reflected in the PY2 workplan.

Activity 7: Support monthly monitoring meetings at the health area level and at the health zone central office level to share information and discuss best practices (one monthly meeting at each level)
IHP supported health zones with preparations and organization of monthly monitoring meetings, including data analysis discussions of indicators.

IR 4.3 Community involvement in health policy and service delivery institutionalized

Activity 1: Support the dissemination of policies on community outreach
No policies were disseminated during this reporting period.

Activity 2: Work with civil society groups to increase their voice and accountability in the provincial planning and policy process
No activities were approved or carried out during this reporting period.

Activity 3: Implement a pilot small grants program for eligible NGOs to increase their institutional other service provision capacity at the community level
This activity will be implemented in PY2.

Activity 4: Support international and national health days, such as International Women's Day, International AIDS Day, Roll Back Malaria, blood donation, fight against tobacco, illiteracy, etc.

IHP supported the promotion of International Breastfeeding Week in Walungu, Katana, and Minova health zones of Bukavu from August 3 to 13. IHP teams supported the health zones to conduct sensitization campaigns towards local leaders, the general community and women's associations. Approximate numbers of participants are found in the table on the following page.

Table 17: Participants in IHP-supported International Breastfeeding Week activities

	Total participants (approx.)	Of which local leaders
Walungu	170	30
Katana	120	36
Minova	140	44

Photo 3: Mtu ni Mtu theater troupe enacts a scene on breastfeeding

Journalists from community radio stations also participated in the International Breastfeeding Week events in all three sites and conducted interviews with participants. The Mtu ni Mtu theater troupe from the National Congolese Radiotelevision Company performed sketches aimed at raising awareness of breastfeeding. All community participants were encouraged to take part in a Q&A session at the end of each event, provoking lively discussions on how to promote breastfeeding further in communities.

II. PROJECT MANAGEMENT

- Additional IHP launch activities: In August, IHP was officially launched in Uvira, in a session with the local political, administrative, and health authorities. IHP explained the objectives of the project, the key activities, key indicators, areas that the project is working, and encouraged the authorities to work in close collaboration. The Territory Administrator demonstrated his support to the project, noting how he rejoiced at the launch of IHP, after the previous support of the AXxes project and called on the population of the target health zones to fully participate in determining their health status through accessing quality health care, and proclaimed his own support for the project.

- USAID and IHP joint visit to Sud Kivu to monitor functionality of Bukavu and Uvira IHP field offices: The purpose of the joint (USAID-IHP-SPS) field visit held July 1-8, 2011, in Sud Kivu was to assess the level of implementation of the IHP in the province and the challenges faced by the project staff and to explore possible solutions. Different aspects and challenges of the project assessed during the visit included: (1) the visibility and the knowledge of IHP from the local provincial, zonal, and community leaders; (2) the functioning of the IHP coordination offices in Bukavu and Uvira; (3) the collaboration between IHP and the drug distribution centers and other provincial health partners; (4) the quality of services provided in USAID- supported health facilities; and (5) the effectiveness of community interventions (community care sites, DOTS, contraceptive distribution, etc.).

The team noted that there was good progress in the status of IHP project implementation and starting activities in Sud Kivu. The project coordination offices were well established and functioning. IHP support to the provincial MOH was well appreciated. However, an extra effort was required from IHP to make the project well known and clearly understood at the health zone, facility, and community levels. USAID and IHP recommended that the project accelerate the finalization of the sub-grant agreements with the health zones, districts, and provinces.

USAID and IHP also agreed that the project needed to ensure more rapid distribution of the PY1 essential medicines to the supported facilities, which would allow the health zone to implement the full package of activities. IHP also needed to define clearly the roles of the three different drug distributors, and enforce a control system to avoid leakage of commodities outside the health system. To ensure quality of services in the different technical areas, IHP will need to monitor activities closely and make sure that quality services are offered and that procedures are followed. To improve efficiency and harmonize the support provided to the assisted health zones, IHP needs to explore the possibility of supporting partners' coordination meetings at both the provincial and the health zone level.

- PY2 workplanning process: IHP used lessons learned from its first year of planning, approval process, and implementation to develop and implement a highly participatory workplanning process for Year 2 that included field-based staff, Kinshasa-based staff, other MSH projects in country, technical advisors from all project partners, and a full contingent of members of the USAID/Kinshasa health team. At a September workshop, IHP set a goal of reviewing and validating the draft workplan for PY 2, with the following general objectives/expectations:
    - Evaluate the implementation of the PY 1 workplan
    - Select priority activities for the PY 2 workplan
    - Revise the PY 2 workplan according to the selected priority activities

  The methodology of the workshop was based on a participatory approach with the aim of strengthening collaboration among consortium members, among the IHP technical specialists, among IHP coordination offices, and between IHP and USAID. There was a mix of presentations about key information, group work followed by presentations, feedback, and discussions in plenary. Participants were pleased with the methodology as is evidenced by comments made during the workshop evaluations. This workshop was facilitated by the internal MSH consultant along with members of the IHP leadership team and the USAID Health Team. Members of the IHP technical team served as daily recorders to provide all present with a record of the proceedings.

  Workshop activities included an evaluation of PY 1; an analysis of successes, challenges, and lessons learned; presentation and discussion of BEST and the GHI; prioritization of activities for PY 2 based on the assessment of PY 1, the baseline study, the BEST Action Plan, the GHI, sector plans, and the PNDS; revision of the PMP indicators; comparison of the workplan to PNDS and other related plans; revision of the plan according to the objective of "integration"; and identification of budget elements for each activity.

  Workshop participants agreed on the following principles in implementing the PY 2 workplan:

    - To maximize cost-effectiveness, attempt to integrate training and supervision activities across technical areas and IRs as appropriate.

- Complete the roles clarification exercise at the national level as soon as possible
- Introduce the roles clarification exercise in each coordination office with both PROSANI staff and key MOH and other partners.
- Ensure that the focus of the LDP is linked to the achievement of indicators and make revisions to the plan as needed

- Status of IHP Year 1 pharmaceuticals order: At the time this report is being written, nearly all of IDA's air shipments have arrived in country and most have arrived at their final destinations (confirmed or awaiting final proof of delivery), or are in country en route to their final destinations (either in transit or pending customs clearance). Surface shipments from India and China which faced initial delays due to a strike in India are now in transit and are estimated to arrive in country in October. The sea shipments from India have arrived in Dar es Salaam and are undergoing customs clearance. The sea shipments from China are expected to arrive in Dar es Salaam on October 28, 2011. Subsequent to customs clearance and delivery time to the CDRs, these drugs are expected to reach their final destinations in November. The remaining surface shipments from IDA are either awaiting flight schedule from carrier to final destination or have been delivered and MSH is waiting for a POD (Bukavu and Mbuji Mayi). The shipments from MissionPharma have arrived in country and are waiting tax exemption documentation. The air shipments arrived in Kinshasa in mid-September and the sea shipment from India will arrive in Dar es Salaam on October 19, 2011. The order from PFSCM has been delivered to Kinshasa.

- Process of hiring the Monitoring and Evaluation and Data Management Director: Due to delays in approval of the selected candidate by the USAID Agreements Officer, DRC-IHP took the initiative to use the USAID AOTR technical approval to hire the candidate before losing him to another organization. The candidate accepted to come on board in this capacity (pending final Agreements Officer approval).

- Process of replacing the DCOP: Again, due to delays in approval of the selected candidate by the USAID Agreements Officer after the AOTR technical approval was provided, DRC-IHP encouraged its partner organization responsible for recruitment of the DCOP to consider taking the same measured risk to avoid losing the selected candidate. It is vital to get a full-time DCOP in place as soon as possible.

- Finalizing the baseline survey: As documented in previous quarters, IHP submitted a full report documenting the baseline study conducted in April-May 2011. After a presentation and technical discussion with USAID, the report was approved. IHP disseminated the findings of the baseline by sharing the technical report with various stakeholders, including the MOH, at different levels and other partners in DRC. In addition, the findings of the baseline study served to align programmatic activities for PY2 during the workplanning session held in Kinshasa, with significant input from technical advisors and staff from all eight coordination offices. Findings of the baseline study are also being used to review performance indicators and targets included in the PMP with USAID.

- Support to health zones, district and provincial authorities: IHP continues to support the Annual Operational Plan process and to provide direct support to health zones pending the approval of the grants template by the USAID Agreements Officer. In addition, IHP considered and shared with USAID requests for changes in support to health zones. One request is to replace the Kalehe health zone with Fizi. This request is pending RSO ruling since security issues are at play.

In addition, the Kasaï Oriental Provincial MOH has requested that the Mutoto health zone be replaced by the Luambo health zone, since Mututo is supported by IRC/DfID and Luambo has no current support.

- Cost share activities: During the last quarter of PY 1, the World Health Organization mission in DRC provided IHP with an interagency emergency health kit (IEHK) to MSH Integrated Health Project to respond to the measles epidemic in 6 IHP-targeted health zones of the DRC, for a total cost share of almost $30,000. Early in PY2Q1, a representative from Project CURE will carry out the assessment necessary to provide the two-container medical supply donation, with an estimated value of $800,000. This cost share contribution is primarily in the form of in-kind contributions derived from the partnership with Project CURE. The USG regulations use the concept of "fair market value" to determine the dollar value of in-kind cost share. Fair market value is defined as the reasonable price that one would pay for comparable goods or services in the environment in which the grantee operates at the time of the donation. IHP will also begin to quantify volunteer services beginning in PY2 and has provided the field with a timesheet to field test. During PY1Q4, MSH submitted, at UNICEF request, a proposal that would provide at least $500,000 of cost share, and potentially double that amount, over the life of the IHP.

- Seven local BCC specialists hired and deployed to regional field offices: In close collaboration with MSH Human Resources, OSC hired and oriented seven BCC specialists during this reporting period. All BCC specialists have since been deployed to their field posts and have begun work to drive results under IR 1.2 and IR 3.

- IHP staff procedures harmonized: The reporting period saw continued close cooperation and harmonization between MSH and OSC home office project managers and IHP staff in Kinshasa. OSC participated in several de-briefs of IHP consultants and OSC and IHP harmonized staff procedures to ensure equal treatment of IHP staff on issues such as medical agreements, installation costs, equipment and professional development.

- Coordination meetings between DRC-IHP implementing partners (MSH, IRC, OSC): To ensure open communication and transparency, DRC-IHP partners are meeting regularly both in-country and via teleconference. Monthly teleconferences take place between MSH and each partner separately, and quarterly coordination meetings take place with the participation of all partners.

III. FAMILY PLANNING AND HIV/AIDS STATUTORY REQUIREMENTS

IHP is aware of the requirement for all project staff, in Kinshasa and in the field offices, to be knowledgeable about all of the family planning and HIV-related statutes enacted by the USG for which the project must ensure compliance. IHP staff members were oriented accordingly and as of today more than 20 of them have confirmed having accessed the USAID course on Family Planning Legislative and Policy Requirements throughout USAID's Global Health eLearning Center[5]. The primary staff members who completed the course and received their certificate include the COP, Technical Advisors (7), Field Office Supervisors (2), Field Office Directors (8), and Provincial Representatives (2). The copy of certificates earned by each project staff will be filed in individual HR folders. During the first quarter of

[5] www.globalhealthlearning.org

PY2, Field Office Directors will assist the field staff in IHP coordination offices to complete the required USAID course on Family Planning Legislative and Policy Requirements and get their certificates.

IHP ordered and distributed to project-supported health facilities 3,280 wall charts on clients' rights and informed choice in family planning, sometimes referred to as "Tiahrt wall charts."

During the recent meeting held on PBF with the USAID health team to collect input on the IHP PBF model and tool, the participants discussed compliance with the Tiahrt Amendment in the context of performance-based financing (PBF). The team recommended that IHP change the family planning indicator to a family planning counseling related indicator.

IV. ENVIRONMENTAL MONITORING AND MITIGATION PLAN

USAID approved the IHP EMMP in July 2011. The plan was translated into French to ensure understanding and use by IHP technical staff members. The French version was shared with the entire staff involved in the implementation of the EMMP. Orientation sessions have been conducted at IHP central and field offices. IHP took the following key steps to implement the EMMP.

Supervision visits: IHP staff, during supervisory visits to health areas, used the checklists from the approved EMMP and noted the methods of waste disposal and the needs to ensure effective waste management. These included: plastic bins with covers, incinerators, waste disposal pits, and placenta disposal pits. IHP staff will support health supervisor to conduct supportive supervision to health facilities that will include assessment of and corrective measures to clinical practices and behaviors at risk of exposing providers, clients, and patients to HIV and other infections.

Medical waste management

- IHP identified and categorized (in three categories) medical wastes for all the IHP clinical subjects (malaria, tuberculosis, HIV, family planning, IMCI, etc.)
- IHP developed specific and appropriate management strategies for each of the three categories of medical waste.

Training and capacity building

- The IHP technical advisors team developed a standard and integrated PowerPoint presentation, which takes into account the Congolese legislation in regard to the environment and specific waste management and the three identified categories of medical waste. This presentation is regularly during all training sessions on clinical aspects, to reinforce the importance of the EMMP.
- IHP conducted training on FOSACOF methodology in the Mwene Ditu coordination area for 28 health providers, focused on the evidence-based improvement of the technical quality of services, including the global environment and the health facilities management with the waste management, medical supplies and drugs, human resources, capacity building and the community mobilization.
- A series of trainings and tools adaptation to EMMP are planned in IHP Year2 workplan.

WASH: In accordance with the EMMP, IHP is procuring arsenic testing kits and portable microbiology labs to conduct water testing.

Rehabilitation of health centers: For each IHP rehabilitation/reconstruction project in the health centers, IHP will conduct an environmental audit in conformity with the EMMP and Congolese guidelines.

IHP workplanning: IHP is finalizing its PY2 workplan; appropriate activities ensure compliance with the EMMP.

V. CHALLENGES ENCOUNTERED

- PMTCT: IHP assessment activities have revealed a number of challenges to PMTCT service delivery. IHP found, particularly in Sud Kivu, insufficient availability of data collection tools at PMTCT sites; infrequent supervision of HIV/AIDS activities by the ECZS or the National AIDS Program, likely due to a lack of supervision costs and the fact that many sites have stopped providing PMTCT services due to lack of materials; lack of suitable infrastructure for quality counseling in most sites (creating problems of confidentiality); and low knowledge of PMTCT, means of HIV transmission, and prevention methods. In some sites, PMTCT activities ceased due to stock outs of supplies after the end of the AXxes Project. Despite these challenges, many women who were unable to be tested for HIV when there were stock outs returned later when they heard that testing supplies were again available. IHP also encouraged health facilities to purchase their own materials if and when possible, and some sites did so. In addition, IHP borrowed 5,000 tests from ProVIC and distributed them rapidly to the project sites.

- Donor incentive payments in selected health zones: In areas where IHP programming overlaps with the DfID-funded health program, which offers incentive payments to service providers, the health zone management teams were disappointed by the IHP approach, which does not give incentive payments. IHP has engaged with these health zones to explain the IHP approach and the other benefits that their zones will receive from IHP's presence there.

- Security in Sud Kivu: The security situation in some areas of Sud Kivu remains precarious due to the presence of armed groups and can delay the implementation of activities. IHP staff were the target of attacks while traveling between Bunyakiri and Kalonge. Shots were fired at the vehicle, and when the vehicle stopped, the passengers were robbed of their belongings. Fortunately no one was injured. The incident was closely followed up by IHP security focal points and reported to USAID. Measures are being applied across Sud Kivu to minimize these risks, including removal of identifying characteristics on vehicles and organizing travel in convoys.

- Air travel: Continued disruptions of air travel and the overall fragile state of the commercial air fleet presents an ongoing problem for operations, affecting the movements and work of IHP staff and short-term technical assistance providers. A solution to this challenge is not immediately evident, but IHP continues to be as flexible as permissible in identifying appropriate air carriers.

- Pharmaceuticals: MSH has two primary suppliers for pharmaceuticals, International Dispensary Foundation (IDA) and MissionPharma (MP), both of which are USAID-approved Procurement

Agents. Through a competitive process, MSH awarded Task Orders to both IDA and MP. Each agent received two orders for IHP's Year 1 needs: one for products to be shipped by air and one for products to be shipped by surface. All of the orders included deliveries to nine final destinations: Kinshasa, Kolwezi, Kananga, Kamina, Mbuji Mayi, Lodja, and three Bukavu locations. As of September 30, 2011, nearly all of IDA's air shipments had arrived in country and most had arrived at their final destinations (confirmed or awaiting final proof of delivery) or were in country en route to their final destinations (either in transit or pending customs clearance). Surface shipments from India and China which faced initial delays due to a strike in India are now in transit and are estimated to arrive in country in October. Subsequent to customs clearance and delivery time to the CDRs, these drugs are expected to reach their final destinations in November. Surface shipments from IDA also were in country by the end of September. The shipments from MissionPharma and PFSCM are in process. Air shipments arrived in September with MissionPharma's surface shipments to follow.
Despite this good progress, the Year 1 initial order was challenging, and IHP dealt with numerous obstacles in getting the pharmaceuticals to their final destinations. IHP appreciated USAID's support in quickly obtaining the necessary Restricted Commodities Approval after it conducted a standard competitive Request for Quotes process. There were some adjustments to the order even in that short period of time due to changes in stock positions in the health zones as well as unforeseen changes in provision of products by other donors (such as a large quantity of Oral Rehydration Salts from UNICEF) which required re-configuring the draft orders for each destination. In addition, when IHP staff in Kinshasa verified the accuracy of the shipping documents for the initial orders which were ready to be shipped by air in May (Packing List, Invoice, Airway Bill), they were instructed to change the "ship to" addresses to the U.S. Embassy in DRC to ensure the shipments would pass through customs smoothly with the Tax Exemption Certificate. This delayed the shipments while the suppliers re-issued the necessary documents and re-labeled the individual cartons.

While MSH has been operating projects with significant pharmaceutical components in a number of different countries over nearly a decade, it had not previously encountered a situation as challenging as this first shipment of drugs into the DRC under the IHP project, particularly as regards one supplier (IDA). The project provided USAID with a chart summarizing the major challenges and how MSH had addressed them on September 11, 2011. Going forward, IHP has reinforced a number of processes to streamline our orders, including the following:

- Hold a meeting with each supplier shortly after the order is placed to review the order requirements and establish a plan of communication, schedule for shipments, etc.
- Require suppliers to provide more frequent updates from the beginning of the orders through final deliveries to all destinations. Initially, these updates may be once or twice weekly, but then will be required on a daily basis to manage any issues that arise and keep moving on actions to resolve issues as MSH has done with IDA through this order.
- Make every effort to split orders of each drug between suppliers to help ensure that a quantity of each drug arrives in country even if one shipment encounters delays.
- Reduce or eliminate changes to the orders to avoid delays, including more up-front discussions and coordination with other donors to avoid duplication of procurement.

While this order was challenging, we are certain that the next order will proceed more smoothly. To summarize, there were delays with Y1 procurement due to a number of reasons that we can expect to avoid in PY 2. Among these were:

1. Unanticipated UNDP distributions of several pharmaceutical products requiring an adjustment in the order to suppliers to avoid oversupply of those products.
2. Longer than expected identification of appropriate CDRs followed by prolonged contract negotiation with CDRs, resulting in delay with notifying suppliers of final shipping points.
3. Consignee and CDR address corrections became necessary. While on the surface, this appears be relatively simple task, it was complicated by the following factors:
   - Ten shipping points with both air and sea shipment
   - Two suppliers who were supplying some items requiring more than one shipment due to manufacturers only being able to provide partial quantities -- each time a change was made, considerable time and effort with computer input of information and reprinting proforma invoices was required.
4. Due to multiple shipping points, air and sea shipments, etc., more than 40 separate shipments were required and each had to be cleared and forwarded.
5. Clearing was an issue due to one supplier (IDA) using multiple freight forwarders who in turn used subcontractors. Some of the forwarders utilized improper clearing procedures resulting in some consignment not yet cleared and distributed.

For PY 2, the efficiency of the procurement process will be improved. IHP will consider preparing a two-year quantification with annual adjustments. This will decrease the time required annually to obtain the required source and origin and waiver (however only a one-year supply will be ordered since funds are only available for the current fiscal year). Next, if the 24-month supply plan is adjusted every 6 months based upon the updated quantification as mentioned above, when the next order is ready to be placed, the amount of time required to prepare that order will be minimized.

Finally, to limit the number of cold chain and narcotic shipments and reduce the overall number of supplier shipments, rather than awarding contracts by item to two or more suppliers, IHP will consider awarding one contract for all drugs and supplies to Sud Kivu and Katanga and a second contract for the two Kasaï (Kananga and Mbuji Mayi). By splitting the award into two lots with one supplier per lot, the quantity of shipments to be cleared, forwarded, and received can be reduced by four-fold (one sea and one air shipment for two provinces instead of a minimum of two sea and two air shipments to four provinces). For PY 2, the clearing and forwarding process will also need to be improved by ensuring that that each supplier designates a single clearing agent. Finally, staff roles and responsibilities have been more clearly defined.

- Delay in procuring IHP goods (vehicles, motorcycles, refrigerators, medical equipment): The outstanding procurements for PY1 include 112 motorcycles, 12 vehicles (1 RAV4 and 11 SUV), 4 boats, 10 solar refrigerators (for vaccines), c-section kits, arsenic testing kits, and blood transfusion kits. The motorcycles and 12 vehicles are currently pending a formal modification for approval from USAID before moving forward with purchasing the vehicles. The boats presented challenges in gathering specifications that would be appropriate for the project needs and then getting quotes from vendors that were able to meet those specifications and having availability for the DRC. After completing research on vendors who may be able to provide the boats, an RFQ was sent to nine vendors. None of the vendors were able to provide a quote and the RFQ was re-competed among 4 additional vendors. An evaluation is expected to be sent to USAID the first week of November requesting approval to purchase a restricted commodity. MSH faced challenges with the solar refrigerators in finalizing the specifications and determining where the final shipping destinations should be. After the specifications were finalized the

successful quote came in above $5,000, so it is currently pending equipment approval. Additional kits were requested in August and September by the project staff. The c-section kits were requested in August and the orders have been placed and are pending delivery. MSH had a challenge finding items that both met the specifications, the quantity needed, and had a fast delivery time. In order to address these challenges, MSH placed two orders. One order had a higher price but a significantly better delivery time. The second order had a more competitive price but a substantially longer delivery time. This way, MSH is able to avoid an unnecessary delay in getting the c-section kits in country. The arsenic testing kits have been competed and winning vendors selected. There will be no necessary approval or waivers needed so the order can be placed and the winning vendors will handle shipment to the DRC. The blood transfusion kits have been ordered and are pending delivery to 6 locations within the DRC. The vendor is handling shipping to the final destination, including customs clearance.

- Contractual issues: As USAID is aware, there are a number of pending approvals from the Agreements Officer/Nairobi that are impeding program progress. As noted above, IHP is finding ways to deal with changes of key personnel based on AOTR technical approval, but no appropriate solution other than direct support to health zones has been possible in the absence of approval of the proposed grant template for the health zones. This is challenging in the IRC-supported IHP health zones since MSH must provide the direct support and has no administrative structure set up in these health zones. We will continue to work with USAID to find solutions to these issues and facilitate more rapid review and approval of submitted requested.

VI. PLANNED ACTIVITIES FOR NEXT QUARTER (OCTOBER TO DECEMBER 2011)

The PY2 workplan and accompanying documents, including the workplan template, workplan narrative, detailed budget, PMP (with Performance Indicator Reference Sheets if completed), and International Travel/STTA Plan, are currently being finalized and will be provided to USAID by the November 15, 2011, due date. The workplan will provide detail on activities for the next quarter.

VII. SUCCESS STORIES

Attached on following pages.

USAID | DEMOCRATIC REPUBLIC OF CONGO

SUCCESS STORY

Protecting Mothers and Babies from Malaria in Katana

In Sud Kivu province, long-lasting insecticide-treated mosquito nets are being distributed to pregnant women and mothers with children

Photo: International Rescue Committee

Rose Muhindu shows her bedroom, where she now sleeps with her baby under a long-lasting insecticide-treated mosquito net.

It is years ago that I last slept under a net. When I got home with this new one I had only one thing on my mind: I can now better protect my children!

–Rose Muhindu

It was a memorable August day for 28-year-old Rose Muhindu, when during a routine visit to the local health center she was offered a long-lasting insecticide-treated mosquito net to use at home.

She was among the first women in Katana, a health zone with a population of almost 180,000, to receive a mosquito net as part of a local distribution campaign. The nets were provided by the President's Malaria Initiative and the campaign was run by the Democratic Republic of Congo-Integrated Health Project (DRC-IHP). Funded by USAID and implemented by several partners – Management Sciences for Health, International Rescue Committee, and Overseas Strategic Consulting, Ltd. – the project covers 80 health zones in four provinces of the DRC. In Sud Kivu province, DRC-IHP was launched earlier this year, and between now and 2015 it will offer support to 28 health zones, among them Katana.

As malaria is one of the leading causes of death and illness in the country, distribution of long-lasting insecticide-treated mosquito nets is a core concern of DRC-IHP. Targeting pregnant women, as well as women with very young children such as Rose Muhindu, the project will distribute more than 117,000 mosquito nets in Sud Kiv during the next four years.

In the Katana heath zone, so far 4,748 women have received mosquito nets. Rose recalls how excited she was the day when she first installed it above her bed, "It is years ago that I last slept under a net. When I got home with this new one I had only one thing on my mind: I can now better protect my children. I thank your project for this very important gift!"

For Rose and her neighbor, just as for the large majority of women in Katana, the cost of mosquito nets at the local market (US$5 for the most basic type) is simply prohibitive. In this health zone, which lies some 50 kilometers away from the provincial capital of Bukavu, an average of almost 5,000 cases of malaria were recorded each month for the past half a year. Numbers are expected to drop following several rounds of mosquito net distribution, and DRC-IHP is continuing to monitor health data in order to measure the impact of the distributions.

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SUCCESS STORY

Strengthening Malaria Treatment Services in Tshumbe

Although malaria is a leading cause of death among children in DRC, progress is being made under a new national policy.

Photo: USAID/ASMED

In Tshumbe, a health care worker explains a diagnosis of malaria and how it will be treated to a young mother.

Nurse Albert Kasongo credits increased malaria detection and a dramatic drop in deaths from malaria to USAID's Democratic Republic of Congo-Integrated Health Project, noting it provides the necessary resources to better manage patient treatment.

Malaria remains a major health problem in the Democratic Republic of Congo (DRC), and children are among those most affected. Across the country, malaria is a leading cause of death for children under age five. In the Tshumbe health zone in Kasaï Oriental province, children with malaria account for more than half of all outpatient visits to health facilities.

Last year, the DRC's National Malaria Control Program enacted a new national policy in response to the gravity of this problem, recommending an approach that included Rapid Diagnostic Tests (RDTs) and Artemisinin-based Combination Therapy (ACT) at the health facility level. In 2010, only 28% of ACT treatment needs were covered in the country's public health facilities.

Today, in Kasaï Oriental province, much of the support to implement the new policy is being provided by the President's Malaria Initiative (PMI) and the USAID-funded DRC-Integrated Health Project (DRC-IHP). Tshumbe is one of the DRC-IHP's 80 targeted health zones, and through PMI and DRC-IHP, health facilities there are receiving supplies of RDTs, ACT medicines, and treated bed nets to prevent infection. All of these commodities are distributed free of charge to local health facilities.

With this support, the Tshumbe I health facility is making strides in the battle against malaria, notes nurse Albert Kasongo. In addition to supplying commodities, the DRC-IHP helped build awareness among local residents that the center was staffed and equipped to provide treatment. Health center staff also reached out to community health workers and local churches to spread the word about the national policy and reinforce the availability of treatment. They also integrated at-home monitoring of cases while improving how their staff received new patients at the health center, so that the community felt welcome.

These strategies are yielding results. Due to increased testing, the number of reported cases of malaria actually went up. In the seven months between January and August 2010 – prior to the DRC-IHP's support – there was an average of 55 cases diagnosed, and a total of 10 deaths from malaria. In the same period in 2011, there were 125 cases diagnosed and treated, and only one death.

SUCCESS STORY
Clean water, better health in Mulambi

In Sud Kivu, access to clean, safe drinking water brings better health to the women and girls tasked with fetching water daily

Photo: International Rescue Committee

Benge Mafisi (right) collects water as her younger sister, Furaha, loads a 25-kilo water container onto her back.

Almost every week one of my children used to get diarrhea or worms. Most of the time we didn't have money to take them to the health center and get treatment… Now the clean water makes all the difference.

–Benge Mafisi

As day breaks in Mulambi, a village spread out between banana groves and fir trees on a mountain 70 kilometers from Bukavu, women and girls load yellow plastic canisters on their heads and begin one of their most arduous tasks of the day: fetching water. In several trips up and down coarse terrain, barefoot and often with babies on their backs, they conquer the steep hills seemingly effortlessly in order to reach water sources kilometers away from their homes.

It is a chore they rarely – if ever – complain about. The one thing that pains them: that after all this effort the precious water frequently causes a score of health problems. All too often collected from unprotected sources, unclean water is at the root of numerous diseases here in Mulambi, as well as in neighboring villages. In fact, according to statistics collected at the Central Bureau of Kaziba health zone, the number of cases of waterborne diseases is greater than the number of cases of malaria or acute respiratory infections – the other prevalent diseases in the area.

Access to clean water is one of the issues at the heart of the USAID-funded Democratic Republic of Congo-Integrated Health Project (DRC-IHP), which was launched in Sud Kivu this year. Between now and 2015, 28 health zones in the province will receive technical and logistical support. As part of the project, each year 30 safe water sources will be built.

Under DRC-IHP, change has already come to Mulambi, which in September became one of the very first villages to get a clean water source. Just a dozen meters away from the old water hole in the muddy soil, the new source is protected by a cemented enclosure and provides safe water from a natural spring.

In fact, women from farther away now come to get water here, even if it means walking an additional few kilometers. Benge Mafisi, a 30-year-old a mother of three, is one of them. "Almost every week one of my children used to get diarrhea or worms," she says. "Most of the time we didn't have money to take them to the health center and get treatment, so they never fully recovered and then they got ill again. Now the clean water makes all the difference. I really am so happy for this change!"

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FROM THE AMERICAN PEOPLE

SUCCESS STORY

Improving Treatment of Tuberculosis in Kalenda

In Kalenda, in the DRC's Kasaï Oriental province, there are only two TB care and treatment centers for more than 195,000 people.

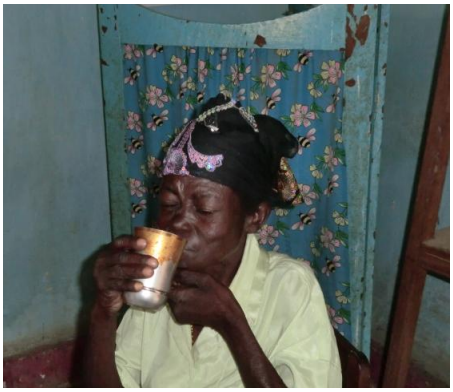

Photo: courtesy of DRC-IHP

In Kalenda, a woman diagnosed with tuberculosis takes her medication following the "Directly Observed Treatment, Short-Course" approach, also known as DOTS.

A new emphasis on patient education, care and treatment has enabled the rate of TB detection and treatment to rise over the past six months.

Tuberculosis is a leading cause of death in the Democratic Republic of Congo, and one of the reasons is a lack of access to diagnosis and treatment for those suffering from the disease. In the health area of Kalenda, in Kasaï Oriental province, there are only two care and treatment centers for a population of more than 195,000 people.

Under the USAID-funded Democratic Republic of Congo-Integrated Health Project (DRC-IHP), efforts are underway to improve the basic health conditions of the Congolese people in 80 health zones in four provinces, including increased care and treatment of tuberculosis (TB).

In Kalenda, the Provincial Health Division has been building the capacity of health workers, with USAID support, since last year. Training focused on reinforcing their skills to help them identify TB cases and better manage patient care. More recently, the DRC-IHP has been leading additional activities to ensure increased testing and better treatment.

The DRC-IHP is supporting the transportation costs of TB commodities to Kalenda's treatment centers. Ensuring the supply of high quality, appropriate medications and supporting patients to complete their doses correctly is particularly important in cases of TB, which has many drug-resistant strains. Under the DRC-IHP, the "Directly Observed Treatment, Short-Course" (DOTS) approach has been implemented; this is the approach globally endorsed by all major health organizations.

In addition, the DRC-IHP launched a community awareness campaign to educate local residents about disease symptoms and the availability of treatment. The project also organized community participation in World TB Day in March 2011, as another way to educate those at risk for the illness.

The new emphasis on patient education, care and treatment has been supported by DRC-IHP's provision of transportation for suspected cases to the two care and treatment centers in Kalenda. This ensures that a greater number of patients in remote areas, who lacked the resources for travel to the centers, are now being tested and treated.

These actions have increased the numbers of people being tested and treated for TB. The rate of TB detection in Kalenda rose from 47.8% of expected cases last year to 81.9% in the first quarter of this year and 100% in the second quarter. Treatment percentages rose from 35.3% to 76% to 84%.

VIII. APPENDICES

Appendix 1: IHP Health Indicators Cumulative PY1
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Appendix 1: Cumulative IHP Health Indicators Project Year 1

INDICATORS	Q1Y1	Q2Y1	Q3Y1	Q4Y1	Cumulative Y1	Target Y1	% Achieved
FAMILY PLANNING							
1. Couple years of protection (CYP) for FP USG-supported programs	82,169	109,807	118,108	119,525	**429,609**	**318,854**	**134.7**
1a. Couple years of protection (CYP) after exclusion of LAM and self-observation methods (NFP) for FP USG-supported programs	27,549	37,335	42,760	44,237	**151,881**		
2. Number of new FP Acceptors in USG supported family planning clinics	10,796	19,705	20,187	20,583	**71,271**	**375,077**	**19.0**
2a.Number of new FP Acceptors of modern methods in USG-supported family planning clinics	82,256	115,584	128,506	128,148	**454,494**		
3. Number of counseling visits for FP/RH as result of USG assistance	54,559	43,505	76,425	73,182	**247,671**		
4. Number of USG-assisted service delivery points providing FP counseling or services	851	930	1,409	1,099	**1,072**	**1,409**	**76.1**
MATERNAL AND CHILD HEALTH							
1. Number of antenatal care (ANC) visits by skilled providers from USG-assisted facilities	71,897	127,931	124,516	103,631	**427,975**	**446,224**	**95.9**
2. Number of deliveries with a skilled birth attendant (SBA) in USG- assisted programs	59,497	97,163	102,505	91,781	**350,946**	**365,116**	**96.1**
3. Number of women receiving Active Management of the Third Stage of Labor (AMTSL) through USG-supported programs	38,893	66,554	77,549	70,349	**253,345**	**277,064**	**91.4**
4. Number of postpartum newborn visits within 3 days of birth in USG-assisted programs	54,906	84,096	93,538	83,762	**316,302**	**348,021**	**90.9**
5. Number of newborns receiving essential newborn care through USG-supported programs	51,704	84,563	92,189	73,809	**302,265**	**336,457**	**89.8**
6. Number of newborns receiving antibiotic treatment for infection from appropriate health workers through USG-supported programs	4,176	16,797	19,906	8,071	**48,950**	**14,965**	**327.1**
7. Number cases of child pneumonia treated with antibiotics by trained facility or community health workers in USG-supported programs	44,848	99,388	91,436	78,447	**314,119**	**451,680**	**69.5**
8. Number of cases of child diarrhea treated in USAID-assisted programs	33,106	56,797	86,188	68,732	**244,823**	**307,309**	**79.7**
9. Number of children less than 12 months of age who received DPTHB3 from USG-supported programs	66,824	93,606	103,159	89,353	**352,942**	**344,258**	**102.5**
10. Dropout rate for DPTHB3	3	8	6	5	**5**		
11. Number of children less than 12 months of age who received vaccine for measles	59,460	91,443	96,421	84,110	**331,434**		
12. Number of children under 5 years of age who received vitamin A from USG-supported programs	629,999	24,346	1,617,774	1,596	**2,273,715**	**2,306,467**	**98.6**
13. Number of pregnant women who received VAT 2+ from USG- supported programs	69,467	108,923	110,167	94,996	**383,553**		

14. Rate of use of health services	20	41	40	31	**33**		
MALARIA							
1. Number of insecticide-treated nets distributed that were purchased or subsidized with USG support	48,965	98,110	93,704	73,332	**314,111**	**800,000**	**39.3**
2. Number of improvements to laws, policies, regulations or guidelines related to improve access to and use of health services drafted with USG support	0	0	0	17	**17**		
3. Number of USG-assisted services delivery points experiencing stock-outs of specific tracer drugs: ASAQ (Artesunate+ Amodiaquine) 50 mg (1 - 5 years)	145	285	203	279	**912**	**6%**	**16.2**
3a. Number of USG-assisted services delivery points experiencing stock-outs of specific tracer drugs: ASAQ (Artesunate+ Amodiaquine) 25 mg (< 1 year)	218	381	467	835	**1,901**	**6%**	**33.7**
4a. Number of artemisinin-based combination treatments (ACTs > 13 years) purchased with USG-support	48,613	49,331	106,962	111,664	**316,570**		
4b. Number of artemisinin-based combination treatments (ACTs 6 - 13 years) purchased with USG-support	16,178	34,194	82,236	88,732	**221,340**		
4c. Number of artemisinin-based combination treatments (ACTs 1 - 5 years) purchased with USG-support	18,307	35,256	78,008	103,662	**235,233**		
4d. Number of artemisinin-based combination treatments (ACTs < 1 year) purchased with USG-support	14,568	17,040	29,840	44,776	**106,224**		
5. Number of children under five with malaria treated correctly following the national protocol	130,708	237,382	225,352	192,866	**786,308**		
6. Percent of pregnant women in target health zones who received IPT	40	54	51	53	**50**		
7.Number of pregnant women with malaria treated correctly following national protocol	17,368	31,673	28,834	29,315	**107,190**		
TUBERCULOSIS							
1. Case notification rate in new sputum smear positive pulmonary TB cases in USG-supported areas	2,182	3,502	3,413	2,762	**11,859**	**4,407**	**269.1**
1a. Case notification rate in new sputum smear positive pulmonary TB cases in USG-supported areas without HZs with high detection rate	1,458	2,167	2,091	1,411	**7,127**		
2. Percentage of all registered TB patients who are tested for HIV through USG-supported programs	16	49	46	35	**37**	**50**	**73.4**
3. Percent of the estimated number of new smear-positive pulmonary TB cases that were detected under DOTS (i.e., case detection rate)	86	93	73	73	**81**	**85**	**95.7**
4. Percent of sputum smear positive pulmonary TB patients that were cured and completed treatment under USG-funded DOTS	93	43	43	31	**53**		
5. Treatment success rate in USG-assisted DOTS Plus programs to treat MDR TB patients	0	0	0	0	**0**	**55**	**0.0**
PMCT							
1.Number of pregnant women seen for ANC in PMTCT facilities	12,116	20,544	56,143	48,863	**137,666**	**96,209**	**143.1**

2.Number of pregnant women receiving HIV counseling	11,900	33,987	34,231	27,235	**107,353**	**96,209**	**111.6**
3.Number of pregnant women receiving HIV counseling and testing	8,707	20,856	19,633	13,737	**62,933**	**76,967**	**81.8**
4.Number of pregnant women receiving HIV counseling and testing; and receiving test results	8,314	18,788	19,217	12,722	**59,041**	**76,967**	**76.7**
5.Number of pregnant women who tested positive	98	200	141	793	**1,232**	**1,231**	**100.1**
6.Number of pregnant women tested HIV positive who receive test results	88	156	131	402	**777**	**1,206**	**64.4**
7.Number of PMTCT health facilities offering PMTCT services	188	547	138	160	**1,033**	**137**	**754.0**
8.Number of pregnant women provided with a complete course of antiretroviral prophylaxis for PMTCT	35	84	101	52	**272**	**985**	**27.6**
9.Number of newborns who received a complete course of antiretroviral prophylaxis	38	85	55	41	**219**	**1,170**	**18.7**
10.Number of partners/husbands of pregnant women who receive HIV counseling and testing and receive results	2,007	2,693	3,450	1,544	**9,694**	**15,513**	**62.5**
11.Number of women receiving CTX and MVI post counseling	139	105	137	554	**935**	**1,231**	**76.0**
12.Number of newborns receiving CTX and MVI	29	45	45	48	**167**	**1,170**	**14.3**
WATER AND SANITATION							
1. Number of People in target areas with access to improved drinking water supply as a result of USG assistance (cumulative during the year)	0	0	0	10,200	**10,200**	**262,380**	**3.9**
2. Number of people in target areas with access to improved sanitation facilities as a result of USG assistance	0	0	500	520	**1,020**	**124,784**	**0.8**
3. Liters of drinking water disinfected with USG-supported point-of-use treatment products					**0**		

Appendix 2: IHP Draft Performance Monitoring Plan

The following is the performance monitoring plan (PMP) that MSH and its partners will use to monitor, assess and report on the overall performance of the Integrated Health Project (IHP). The PMP includes performance indicators according to the project results framework. The PMP will be a living document throughout the implementation of the IHP and will serve to support management decision making to ensure accomplishment of IHP intermediate results and the project objective. Actual figures for performance indicators will be included and updated according to the means of verification. Upon completion of the mid-term review and with input from USAID, MSH and its partners will review and revise end-of-project targets as necessary.

Indicator		Definition	Baseline	Annual Benchmarks					End-of-Project Target	Means of Verification		
				Yr 1	Yr 2	Yr 3	Yr 4	Yr 5		Data Source	Frequency	Person Responsible
USAID/DRC/IHP Objective: increase use of high-impact health services, products, and practices for FP, MNCH, nutrition, malaria, NTDs, TB, HIV&AIDS, and WASH in target health zones												
1	**FP**: Couple years of protection (CYP) in USG-supported programs	The estimated protection provided by FP services during a one-year period, based upon the volume of all contraceptives provided to clients in the IHP target areas during that period	315,697	318,854	322,043	325,263	328,516	331,801	331,801	HMIS	Monthly	M&E Specialist HMIS Officers
2	**FP**: # of new acceptors for any modern contraceptive method in USG-assisted family planning (FP) service delivery points	Number of new FP acceptors of a modern method will be calculated based upon records from USG-supported FP clinics in the IHP target areas	364,152	364,152	375,077	386,329	397,919	409,857	409,857	HMIS	Monthly	M&E Specialist HMIS Officers
3	**FP**: Number of USG-assisted	Number of USG-supported service	1,321	1,467	1,487	1,487	1,487	1,487	1,487	HMIS	Quarterly	M&E Specialist

	delivery points providing family planning (FP) counseling or services	delivery points (excluding door-to-door CBD) providing FP counseling or services, disaggregated by type of service										HMIS Officers
4	**MNCH**: # of antenatal care (ANC1) visits by skilled providers from USG-assisted facilities	# of pregnant women with at least one antenatal care (ANC) visit by skilled providers from USG-assisted health facilities in the IHP target areas	433,227	446,224	459,611	473,399	487,601	502,229	502,229	HMIS	Monthly	M&E Specialist HMIS Officers
5	**MNCH**: # of antenatal care (ANC4) visits by skilled providers from USG-assisted facilities	# of pregnant women with at least four antenatal care (ANC) visits by skilled providers from USG-assisted health facilities in the IHP target areas	tbd	tbd	tbd	tbd	tbd	tbd	tbd	HMIS	Monthly	M&E Specialist HMIS Officers
6	**MNCH**: Number of deliveries with a skilled birth attendant (SBA) in USG-assisted facilities	Number of deliveries with a skilled birth attendant (SBA) in USG-supported facilities in the IHP target area	351,073	365,116	379,721	394,909	410,706	427,134	427,134	HMIS	Monthly	M&E Specialist HMIS Officers
7	**MNCH**: # of women receiving Active	Number of women giving birth who received Active	258,938	277,064	296,458	317,210	339,415	363,174	363,174	HMIS	Monthly	M&E Specialist HMIS

	Management of the Third Stage of Labor (AMTSL) through USG-assisted programs	Management of the Third Stage of Labor (AMSTL) through USG-supported programs/IHP target area										Officers
8	**MNCH**: Number of postpartum newborn visits within 3 days of birth in USG-assisted programs	Number of postpartum/ newborn visits within 3 days of birth in USG-assisted programs/IHP target area	334,636	348,021	361,942	376,420	391,477	407,136	407,136	HMIS	Monthly	M&E Specialist HMIS Officers
9	**MNCH**: Number of newborns receiving essential newborn care through USG-supported programs	Number of newborn infants who received essential newborn care through USG-supported programs/IHP target area	323,516	336,457	349,915	363,912	378,468	393,607	393,607	HMIS	Monthly	M&E Specialist HMIS Officers
10	**MNCH**: Number of newborns receiving antibiotic treatment for infection from appropriate health workers through USG-supported programs	Number of newborn infants identified as having possible infection who received antibiotic treatment from appropriately trained facility, outreach or community health workers through USG-supported programs/ IHP target area	14,529	14,965	15,414	15,876	16,353	16,843	16,843	HMIS	Monthly	M&E Specialist HMIS Officers

11	**MNCH**: Number cases of child pneumonia treated with antibiotics by trained facility or community health workers in USG-supported programs	Number of cases of child pneumonia treated with antibiotics by trained facility or community health workers in USG-supported programs/IHP target area	430,171	451,680	474,264	497,977	522,876	549,019	549,019	HMIS	Monthly	M&E Specialist HMIS Officers
12	**MNCH**: Number of cases of child diarrhea treated in USG-supported programs	Number of cases of child diarrhea treated through USG-supported programs/IHP target area with Oral Rehydration Therapy (ORT) or ORT plus zinc supplements	292,675	307,309	322,674	338,808	355,748	373,536	373,536	HMIS	Monthly	M&E Specialist HMIS Officers
13	**MNCH**: Number of children less than 12 months of age who received DPT-HepB-Hib 1-3 from USG-supported programs	Number of children less than 12 months who received three doses of DPT, Hepatitis B, and Haemophilus Influenza (DPTHepBHib1-3) vaccine in a given month from USG supported programs/IHP target area	324,772	344,258	364,914	386,809	410,017	434,618	434,618	HMIS	Monthly	M&E Specialist HMIS Officers

14	**MNCH**: Drop-out rate in DPTHepB-Hi1-3 among children less than 12 months of age	Numerator: Number of children less than 12 months who did not complete the full regimen of DPTHB3 vaccination Denominator: All children less than 12 months who received DPT-HepB-Hi1-3	6%	5%	5%	5%	5%	5%	5%	HMIS	Monthly	M&E Specialist HMIS Officers
15	**MNCH**: Number of children less than 12 months of age who received measles vaccine from USG-supported programs	Number of children less than 12 months of age who received measles vaccine in a given month from USG supported programs/IHP target area	308,533	327,045	346,668	367,469	389,516	412,887	412,887	HMIS	Monthly	M&E Specialist HMIS Officers
16	**NUTRITION**: Number of children under 5 years of age who received vitamin A	Number of children under 5 years of age who received vitamin A from USG-supported programs/IHP target area.	2,239,288	2,306,467	2,375,661	2,446,930	2,520,338	2,595,949	2,595,949	HMIS	Monthly	M&E Specialist HMIS Officers
17	**NUTRITION :** Proportion of pregnant women who received iron folate to prevent anemia	Numerator: Number of women in the 9th month of pregnancy who have received iron folate tablets to	tbd	tbd	tbd	tbd	tbd	tbd	tbd	HMIS	Monthly	M&E Specialist HMIS Officers

		prevent anemia during the last five months of pregnancy Denominator: Total number of pregnant seen at ANC										
18	**NUTRITION:** Number of mothers of children 2 years of age or less who have received nutritional counseling for their children	Number of mothers of children 2 years of age or less who have received nutritional education within group support	tbd	tbd	tbd	tbd	tbd	tbd	tbd	HMIS	Monthly	M&E Specialist HMIS Officers
19	**NUTRITION:** Number of breastfeeding mothers receiving vitamin A	Number of breastfeeding mothers attending post natal visits during the 8 weeks following delivery who received vitamin A	tbd	tbd	tbd	tbd	tbd	tbd	tbd	HMIS	Monthly	M&E Specialist HMIS Officers
20	**TB**: Case Notification rate in new sputum smear positive pulmonary TB cases	Numerator: Number of new sputum smear positive pulmonary TB cases reported in the past year Denominator: Total population in the specified geographical area (x100,000)	17,115	17,626	18,156	18,700	19,261	19,839	19,839	Health facility records	Quarterly	M&E Specialist HMIS Officer
21	**TB:** Percent of all	Numerator:	tbd	tbd	tbd	tbd	tbd	tbd	tbd	Health	Quarterly	M&E

	registered TB patients tested for HIV in TB screening and treatment health facilities offering HIV testing	Number of TB patients who are tested for HIV Denominator: Number of registered TB patients in TB screening and treatment health facilities offering HIV testing								facility records		Specialist HMIS Officer
22	**TB**: Case detection rate	Numerator : Number of cases notified (sum of new and relapse sputum positive TB cases) Denominator : Estimated number of TB cases expected	83%	85%	87%	90%	93%	95%	95%	Health facility records	Quarterly	M&E Specialist HMIS Officer
23	**TB**: Number of multi-drug resistance (MDR) TB cases detected	Number of TB cases with multi-drug resistance registered in USG-supported facilities	NA	NA	20	40	60	80	80	Health facility records	Quarterly	M&E Specialist HMIS Officer
24	**TB :** Number of USG-assisted service delivery points experiencing stock-outs of RHE (rifampicin, isoniziad, ethambutol) combination	Number of USG-assisted service delivery points (SDPs) experiencing stock-out of TB drugs at any time during the defined reporting period										
25	**HIV/PMCT:**	Number of	89,082	96,209	102,943	110,149	117,860	126,110	126,110	Health	Monthly	M&E

	Number of pregnant women seen for ANC in facilities that offer PMTCT	pregnant women seen for ANC in facilities that offer prevention of mother-to-child transmission services								facility records HZ Reports		Specialist HMIS Officer
26	**HIV/PMCT:** Number of pregnant women receiving HIV counseling	Number of pregnant women who received counseling services for HIV (advice to prevent mother -to-child transmission)	87,639	96,209	102,943	110,149	117,860	126,110	126,110	Health facility records HZ Reports	Monthly	M&E Specialist HMIS Officer
27	**HIV/PMCT:** Number of pregnant women receiving HIV counseling and testing	Number of pregnant women who received counseling and testing services for HIV	76,216	76,967	82,354	88,119	94,288	100,888	100,888	Health facility records HZ Reports	Monthly	M&E Specialist HMIS Officer
28	**HIV/PMTCT:** Number of pregnant women who were tested for HIV and know their results	Number of pregnant women who were counseled and tested for HIV and know their results [Number of pregnant women with known HIV status]	75,091	76,967	82,354	88,119	94,288	100,888	100,888	Health facility records HZ Reports	Monthly	M&E Specialist HMIS Officer
29	**HIV/PMTCT:** Number of pregnant women who tested positive for HIV	Number of pregnant women who tested HIV positive	659	1,231	1,318	1,410	1,509	1,614	1,614	Health facility records	Monthly	M&E Specialist HMIS Officer
30	**HIV/PMCT:** Number of	The number of women with	585	1,206	1,292	1,382	1,494	1,598	1,598	Health facility	Monthly	M&E Specialist

	pregnant women with known HIV status	known (positive) HIV infection attending ANC for a new pregnancy over the last reporting period								records		HMIS Officer
31	**HIV/PMTCT:** Number of health facilities providing ANC services that provide both HIV testing and ART for PMTCT on site	The number of health facilities in IHP target areas where antenatal services, HIV counseling and testing, and ARV to prevent mother-to-child transmission of HIV are provided in the same site.	137	137	187	250	350	400	400	Health facility records	Monthly	M&E Specialist HMIS Officer
32	**HIV/PMTCT:** Number of HIV-positive pregnant women who received antiretroviral drugs to reduce risk of mother-to-child transmission	Number of HIV-positive pregnant women who received antiretroviral treatment (ART) to reduce the risk of mother- to-child transmission during the reporting period disaggregated by regimen type	413	985	1,054	1,128	1,207	1,291	1,291	Health facility records	Monthly	M&E Specialist HMIS Officer
33	**HIV/PMTCT:** Number of newborns who received antiretroviral (ART) prophylaxis to reduce risk of	Number of newborns whose mothers are HIV-positive and who received antiretroviral prophylaxis at	273	1,170	1,252	1,339	1,433	1,533	1,533	Health facility records	Monthly	M&E Specialist HMIS Officer

	mother-to-child transmission	birth										
34	**HIV/PMTCT:** Number of partners/husbands of pregnant women who receive HIV counseling and testing and received their results	Number of husbands/partners of pregnant women who received HIV counseling and testing in health centers and hospitals and know their results within the IHP target area	7,783	15,513	17,431	19,451	21,575	23,810	23,810	Health facility records	Monthly	M&E Specialist HMIS Officer
35	**HIV/PMTCT:** Number of HIV+ pregnant women receiving cotrimoxazole (CTX) prophylaxis	Number of HIV-positive pregnant women who received Cotrimoxazole prophylaxis, disaggregated by age (<15, 15+)	756	1,231	1,318	1,410	1,509	1,614	1,614	Health facility records	Monthly	M&E Specialist HMIS Officer
36	**HIV/PMTCT:** Percent of infants born to HIV-positive pregnant women who are started on CTX prophylaxis within two months of birth	**Numerator:** Number of infants born to HIV-infected women that are started on Cotrimoxazole prophylaxis within two months of birth at USG supported sites within the reporting period **Denominator**: Number of HIV-positive pregnant women identified	203	1,170	1,252	1,339	1,433	1,533	1,533	Health facility records	Monthly	M&E Specialist HMIS Officer

		in the reporting period (include known HIV-positive at entry										
37	**HIV/PMTCT:** Number of HIV-positive pregnant women assessed for ART eligibility	Number of HIV-positive pregnant women assessed for ART eligibility through either clinical staging (using WHO clinical staging criteria) or CD4 testing in USG-supported sites	tbd	tbd	tbd	tbd	tbd	tbd	tbd	Health facility records	Monthly	M&E Specialist HMIS Officer
38	**HIV/PMTCT:** Number of USG-assisted service delivery points experiencing stock-outs of combination ARV drugs	Number of USG-assisted service delivery points (SDPs) experiencing stock-outs of ARV drugs at any time during the defined reporting period	tbd	tbd	tbd	tbd	tbd	tbd	tbd	Health facility records	Monthly	M&E Specialist HMIS Officer
39	**HIV/PMTCT:** Number of individuals who received Testing and Counseling (T&C) services for HIV and received their test results (P11.1 D PEPFAR)	Number of individuals who received T&C services for HIV and received their test results during the reporting period. ○ *By sex: Male and Female* ○ *By age: <15 and 15+* ○ *By test result:*	tbd	tbd	tbd	tbd	tbd	tbd	tbd	Health facility records	Monthly	M&E Specialist HMIS Officer

		Positive, Negative ○ *By type of counseling/test: Individual, Couple*										
IR 1.1: Facility-based health care services and products (provincial hospitals and district health centers) in target health zones increased												
40	% of GRHs implementing CPA-plus	Numerator: # of GRHs implementing CPA-plus Denominator: Total # of GRHs	9%	20%	40%	50%	60%	70%	70%	Rapid health facility (GRH and HC) survey	Annually	M&E Specialist GRH Manager
41	% of health centers implementing MPA-plus	Numerator: # of health centers implementing MPA-plus Denominator: Total # of health centers	16%	35%	50%	60%	70%	80%	80%	Rapid health facility (GRH and HC) survey	Annually	M&E Specialist HC Director
42	% of USG-assisted service delivery points experiencing stock-outs of specific tracer drugs	Numerator: Number of USG-assisted service delivery points (SDPs) experiencing stock-out at any time during the defined reporting period of specific tracer drugs offered by the SDP in IHP target area. Tracer drugs list includes: Malaria (ACT for <5), FP (xx), MNCH (CTX),		tbd	tbd	tbd	tbd	tbd	tbd	Health facility (GRH and HC) records	Quarterly	M&E Specialist HMIS Officer

		and TB (xx) (refer to FOSACOF Manual, Annex 5, FOSACOF Drug List) Denominator: Total number of USG-assisted service delivery points										
43	**MALARIA**: Percent of pregnant women who received at least two doses of SP for Intermittent Preventive Treatment (IPT) during ANC visits	Numerator: Number of pregnant women who received at least two doses of SP for IPT during ANC visits Denominator: Total number of pregnant women attending ANC visits in the reporting period	NA	50	55	58	tbd	tbd	tbd	HMIS IHP records	Quarterly	M&E Specialist, HMIS Officers Malaria Advisor
44	**MALARIA :** Number of ACTs purchased with USAID/PMI funds and distributed in health facilities and CCM sites	Total number of ACT blisters purchased and distributed with USAID/PMI funds in health centers and general referral hospitals. Distribution will also be carried out through community health workers (relais communautaires), disaggregated by		1,500,000	2, 000,000	TBD	tbd	tbd	tbd	HMIS IHP records	Quarterly	M&E Specialist, HMIS Officers Malaria Advisor

		age group										
45	**MALARIA :** Number of health care providers trained in intermittent prevention treatment in pregnancy (IPTp)	Number of health care providers trained in prevention (IPT LLINs) disaggregated by sex	0	1,500	2,400	tbd	tbd	tbd	tbd	IHP records NMCP training records	Quarterly	IHP Capacity Building Specialist IHP Malaria Advisor
46	**MALARIA**: Number of health care providers trained in performing rapid diagnosis test (RDT) and case management of uncomplicated malaria cases	Number of health care providers trained in diagnostic (RDT and microscopy), and case management of uncomplicated malaria with ACTs disaggregated by sex										
47	**MALARIA**: Number of malaria rapid diagnostic test (RDTs) purchased with USAID/PMI funds and distributed to health facilities	Number of malaria RDTs purchased and distributed within the IHP target areas during the reporting period	0	500,000	850,000	TBD	TBD	TBD	TBD	HMIS, NMCP records IHP records	Quarterly	M&E Specialist, HMIS Officers Malaria Advisor
48	**MALARIA:** Number of insecticide treated nets (ITNs) distributed that were purchased or subsidized with USG funds	Number of ITNs purchased or subsidized with USG funds that were distributed within the IHP target area	589,753	250,000	455,000	tbd	tbd	tbd	tbd	HMIS, IHP records	Annually	M&E Specialist, HMIS Officers
49	**MALARIA :**	Number of USG-	tbd	tbd	tbd	tbd	tbd	tbd	tbd	HMIS, IHP	Annually	M&E

	Number of USG-assisted service delivery points experiencing stock-outs of ACT for 1-5 year olds	assisted service delivery points (SDPs) experiencing stock-out of ACT for 1 – 5 years at any time during the defined reporting period								records		Specialist, HMIS Officers
IR 1.2: Community-based health care services and products in target health zones increased												
50	#/% of communities with CODESAs actively involved in management of priority health services	Numerator: # of communities with CODESAs with active involvement in management of priority health services for their communities Denominator: Total # of communities in IHP target area	50%	55%	70%	80%	90%	100%	100%	IHP records	Quarterly	M&E Specialist CODESA leader
51	# of people in target areas with access to improved drinking water supply as a result of USG assistance	Improved drinking water technologies are those more likely to provide safe drinking water than those characterized as unimproved	233,580	262,380	252,000	252,000	252,000	252,000	1,000,800	IHP records	Annually	M&E Specialist
52	# of people in target areas with access to improved sanitation facilities as a result of USG assistance	Improved sanitation facilities include those more likely to ensure privacy and hygienic use, e.g., connection to a	123,284	124,784	126,284	127,784	129,284	130,784	130,784	IHP records	Annually	M&E Specialist

		public sewer, connection to a septic system, pour-flush latrine, simple pit latrine, and ventilated improved pit (VIP) latrine										
IR 1.3: Engagement of provincial management with health zones and facilities to improve service delivery increased												
53	#/% of senior LDP teams that have achieved their desired performance according to indicators in their action plans within six months of completing the LDP	Leadership Development Program (LDP) team made up of senior health managers working towards improving organizational performance and service delivery of health zones and facilities in their respective health zones/areas	23 (29%)	23 (29%)	35 (44%)	52 (65%)	80 (100%)	80 (100%)	80 (100%)	LDCP training reports	Semi-annually	LDP Coordinator M&E Specialist
54	#/% of HZs with validated action plans	Numerator : # HZ with validated actions plans Denominator : Total # HZ in IHP target area	80%	90%	100%	100%	100%	100%	100%	IHP records	Annually	M&E Specialist
IR 2: Quality of key family health care services in target health zones increased *(Component 1)*												
IR 2.1: Clinical and management capacity of health care providers increased												
55	# of health care providers at GRHs and HCs following IMCI protocols for childhood illness	# of health care providers at GRHs and HCs correctly classifying and treating childhood illnesses, disaggregated by	15%	25%	35%	45%	55%	65%	65%	Rapid health facility (GRH and HC) survey	Semi-annually	M&E Specialist HMIS Officer

		childhood illness										
56	# of facilities with accurate and up-to-date inventory records, disaggregated by type of facility	Accurate means that the records correctly reflect the inventory of essential drugs and supplies that are currently in-stock	5%	30%	50%	75%	90%	100%	100%	Rapid health facility (GRH and HC) survey	Semi-annually	M&E Specialist HMIS Officer
57	**GENDER:** # of health workers clinically trained in case management of sexual violence	# of health workers at HCs and GRHs who successfully completed clinical training sessions on sexual violence case management in IHP target health zones	NA	NA	1,120	1,480	1,840	2,200	2,200	IHP training sign-in sheets	Quarterly	Gender Technical Advisor Health Zone Management Team
IR 2.2: Minimum quality standards for health facilities (provincial hospitals and district health centers) and services developed and adopted												
58	#/% of health facilities meeting all nine FOSACOF minimum standards, disaggregated by type of health facility	Numerator: # of health facilities meeting all nine FOSACOF minimum standards Denominator: Total # of facilities	8%	22%	36%	51%	65%	79%	79%	HF (GRH and HC) records	Semi-annually	M&E Specialist HMIS Officer
IR 2.3: Referral system for primary health care prevention, care and treatment between community structures and health facilities (district and provincial levels) institutionalized												
59	#/% of patients referred to HCs, disaggregated by illness, gender, and age	# of patients (adults and children) referred to Health Centers by a CHW	15%	20%	25%	30%	35%	40%	40%	HF records	Quarterly	HMIS Officer
60	#/% of patients referred to GRHs,	# of patients (adults and	5%	10%	15%	20%	25%	25%	25%	HF records	Quarterly	HMIS Officer

	disaggregated by illness, gender, and age	children) referred to GRHs by a CHW or health care provider										
IR 3: Knowledge, attitudes, and practices to support health-seeking behaviors in target health zones increased *(Component 1)*												
IR 3.1: Evidence-based health sector-community outreach linkages –especially for women, youth and vulnerable populations– established												
61	# local NGO coordination meetings	# of local NGO coordination meetings organized by Sr. BCC specialist	ND	4	16	16	16	16	68	IHP records	Annually	BCC Technical Advisor
62	% of NGOs representing women, youth and vulnerable groups participating in coordination meetings	Numerator: # of NGOs representing women, youth, and vulnerable groups attending NGO coordination meetings Denominator: # of NGOs representing women, youth and vulnerable groups registered in DRC	ND	15%	20%	25%	30%	40%	40%	IHP records	Annually	BCC Technical Advisor
63	# Community Champions selected and trained	# Community Champions completing capacity building program led by IHP community mobilizers	0	500	1,200	2,000	3,000	4,000	10,700	IHP records	Quarterly	BCC Technical Advisor
64	# Community health action plans created	# Community health action plans developed by community members and reviewed by IHP	ND	250	350	700	1,200	1,423	1,423	IHP records	Quarterly	BCC Technical Advisor

		staff										
65	# Youth organizations participating in youth education outreach strategy	# Youth organizations conducting member outreach and health education as part of IHP youth health education strategy	ND	30	50	120	120	120	120	IHP records	Quarterly	BCC Technical Advisor
IR 3.2: Health advocacy and community mobilization organizations strengthened												
66	# CODESAs trained in Community Driven Reconstruction methodology	# CODESAs completing training in CDR methodology	0	0	tbd	tbd	tbd	tbd	tbd	IHP records	Annually	BCC Technical Advisor
67	# of CODESAs supported by IHP and which have a communications action plan developed	# of CODESAs supported by IHP within the IHP target area and which have a communications action plan developed	0	1540	1,540	1,540	1540	1,540	1540	IHP records		BCC Technical Advisor
IR 3.3: Behavior change campaigns involving opinion leaders and cultural influences (people and technologies) launched												
68	**GENDER:** # of BCC campaigns launched delivering key health messages targeting women and girls as primary audience	# of BCC campaigns developed and launched with key prevention priority messages for FP, nutrition, malaria, and WASH within the IHP target areas	ND	0	3	4	4	4	15	IHP records	Quarterly	BCC Specialist, BCC Technical Advisor
69	# of educational SMS messages in	Key messages targeted to select	NA	NA	tbd	tbd	tbd	tbd	tbd	IHP records	Quarterly	BCC Specialist,

	key health domains	groups (mothers, caretakers, partners, etc.) sent via SMS in FP, nutrition, malaria, WASH, etc., within the IHP target areas (annual targets will be based on pilot studies in PY2 as included in the workplan)										BCC Technical Advisor
70	# of community champion committees established	A community champion committee is composed of community leaders. Each committee will work closely with its community members so they become agents of change by taking the lead in planning, implementing and monitoring community-based programs to improve the health of families and individuals.	NA	NA	8	16	24	24	72	IHP records	Quarterly	BCC Specialist, BCC Technical Advisor
IR 4: Health sector leadership and governance in target provinces improved *(Component 2)*												
IR 4.1: Provincial health sector policies and national level policies aligned												
71	% of health zones adopting health	Numerator: # of health zones with	12%	20%	50%	80%	100%	100%	100%	Health zones	Annually	M&E Specialist

	sector policies in alignment with national MOH policies	policies developed and adopted in line with national MOH policies Denominator: Total # of HZ								records		IHP Field Director
IR 4.2: Evidence-based tools for strategic planning and management decision-making adopted												
72	% of Health Zones with a performance management system that includes essential components	Numerator: # of Health Zones with a performance management system that includes any of the three essential components: up-to-date job descriptions, lines of supervision, and joint work planning and performance review Denominator: Total # of HZ	10%	20%	50%	80%	100%	100%	100%	Health zone human resource documents	Annually	M&E Specialist IHP Field Director
IR 4.3: Community involvement in health policy and service delivery institutionalized												
73	% of community leaders trained and actively involved in health management and services	Numerator: # of community leaders trained by IHP and involved in health management and services Denominator: Total # of community leaders	15%	20%	30%	40%	50%	60%	60%	IHP records	Annually	M&E Specialist

Appendix 3: Approved Quarterly Workplan

	IHP Workplan For June 1 – September 30, 2011
	Activities By IRs
	Component 1, IR 1 *Access to and availability of Minimum Package of Activities/Complementary Package of Activities plus (MPA/CPA-plus) services in targeted health zones increased*
Activity 1	**MPA/CPA-plus capacity and needs assessment of HCs and GRHs**
1.1	Conduct a workshop in collaboration with MOH and Implementing Partners to finalize FOSACOF tools for HGR and Health Zones.
1.2	Complete the evaluation of MPA and CPA plus implementation, noting critical gaps in delivery capacity in the health centers and reference hospitals in the target health zones, in coordination with MOH and implementing partners.
Activity 2	**Commodities (pharmaceuticals, medical equipment and supplies and environmental health supplies) availability and management**
2.1	Conduct procurement and distribution of IHP Year 1 Commodities (i.e. pharmaceuticals, medical equipment and supplies and environmental health supplies), with SPS technical assistance.
2.2	Contract with eight (8) CDRs (regional distribution centers/warehouses) for the management of IHP pharmaceuticals to be distributed to the 80 HZs: 3 CDRs in Bukavu (8eme CEPAK, APAMESK and BDOM), FODESA in Lodja, CADMEKO in Mbuji Mayi, CADIMEK in Kananga, CEDIMEK in Kolwezi and CEDIMEK in Kamina.
2.3	Ensure the quality control of drugs at the port of entry, in the CDRs, and in the health facilities, with SPS technical assistance.
2.4	Provide technical support for the tracking of financial and pharmaceutical management indicators at health facility.
2.5	Provide technical support for the adaptation of the standard procedures of pharmaceuticals management (s) to the current situation at all levels, with SPS technical assistance.
Activity 3	**Supervision and coordination**
3.1	Provide financial and technical support to Provincial and District levels in carrying out supportive supervision at the Zonal level (one supervision visit per health zone per quarter). The trainings in LDP and FOSACOF for provincial, district and zonal levels will contribute to improving the quality of supervision activities.
3.2	Provide financial and technical support for the Provincial Steering Committee (CPP) meetings, in coordination with other implementing partners working in target Provinces.
3.3	Provide financial and technical support to the mid-level (DPS, DS et EPI unit) and local level (health zones and reference hospitals) in the coordination of their activities.
3.4	Provide financial and technical support to 80 health zones for monthly supervision to health centers and Coordination and monitoring meetings.
	Component 1, IR 2 *(Quality of MPA/CPA-plus services in target health zones increased):*
Activity 4	***Ordinogrammes***
4.1	Provide technical and financial support in organizing a workshop for finalization of IMCI component of the "*ordinogramme*" manual.
4.2	Print at least 1600 "ordinogrammes" copies to be distributed to at least 1500 health centers (1 per HC), to health zones, districts and DPS for reference document for trainers and supervisors.
4.3	Organize 1 ToT session for Kolwezi, Kamina, Bukavu, Uvira, Luiza, Tshumbe, Mwene Ditu and Kole. Each session is planned for 20-25 participants from different bureau of medical inspection, local NGO and other partners (to be identified with provincial l health authority).
4.4	Train 2 service providers per health center (HC) for at least 400 HCs selected among the most remote HCs in the HZs of Kolwezi, Bukavu, Uvira, Kole, Kamina, Luiza, Tshumbe and Mwene Ditu on the use of *"ordinogrammes."*

Activity 5	**LDP & FOSACOF**
5.1	Train Provincial-level management team (*Equip Cadre*) as well as the District-level team in FOSACOF to enable them to supervise implementation of these activities. The 4 provinces are targeted.
5.2	Evaluate quality improvement needs at health facilities, with zonal and community authorities, using FOSACOF tools, to guide ECZs in developing training and supportive supervision plans and budgets specific to the needs of their zones.
5.3	Conduct supportive supervision training to reorient supervision to coaching and mentoring in support of quality improvement targets as identified in the FOSACOF, as part of FOSACOF Training for Supervisors.
5.4	Scale up at least in 400 HCs a whole-site, standards-based quality improvement approach at prioritized health facilities (i.e. where FOSACOF has not yet been introduced), coordinated with LDP workshops.
5.4.1	Train 114 selected health zones team members (2 HZ members for 57 HZ) in FOSACOF and quality assurance.
5.4.2	Train 855 selected health providers (3 providers for 5 HC * 57 HZ) and 1425 community members (5 community members * 5 HC * 57 HZ).
5.5	Conduct five-day LDP ToTs for trainers of DPS and districts in Lubumbashi, Mbuji Mayi and Kananga.
5.6	Conduct Senior Alignment meetings (for provincial and district authorities) in Lubumbashi, Mbuji Mayi and Kananga.
5.7	Conduct LDP Workshop 1 on Scanning for supported HZs covered by IHP Coordination offices in Bukavu, Uvira, Mwene Ditu, Kole, Tshumbe, Kolwezi and Kamina.
Activity 6	**Immunization**
6.1	Train 72 (38 HZ * 2 members) ECZ members in the EPI Mid-level Management (MLM) and DQS course in Luiza, Bukavu and Uvira.
6.2	Provide logistical and technical support, in complementary and coordination with other partners, to following vaccination activities:
6.2.1	Measles immunization campaign in targeted HZs in Mwene Ditu, Tshumbe, Kole and Bukavu.
6.2.2	Polio immunization campaign in targeted HZs in Mwene Ditu and others HZs targeted in the IHP coordination supported HZs.
6.2.3	Introduction of the new vaccine PCV13 in Bukavu and Uvira.
6.3	Provide technical, logistical and financial support to the EPI national program to finalize the inventory of cold chain in the IHP 80 HZs.
6.4	Provide regularly EPI tools to HZs for data collection and data analysis.
6.5	Assess EPI data quality to identify HZ with low performance and consequently plan supportive supervision as part of the follow-up of EPI Mid-level Management (MLM) and DQS training conducted for Tshumbe and Kole HZs and of recommendations from MCHIP site visits in Bukavu and Uvira.
6.6	Participate in the national coordination meetings (CNC) and CCIA meetings.
6.7	Provide technical and financial support to CCIA meetings at provincial and HZ levels.
Activity 7	**Nutrition**
7.1	Finalize the hiring process of IHP Nutrition Advisor.
7.2	Hire an international consultant with strong experience working in nutrition programs in Africa and more specifically in DRC to support IHP in design best strategies in mainstreaming nutrition interventions at community and health facility levels, develop an implementation plan, and train the nutrition advisor and other technical staff accordingly.
7.3	Provide technical, logistical and financial support to HZs to integrate supervision of routine nutrition activities in health facilities' consultations (ANC, CPON, CPS, etc) as priority activities of their monthly field visits.
7.4	Provide technical, logistical and financial support to vitamin A mass campaign when it is planned in IHP supported HZs.
7.5	Continue dialog with partners (WFP, UNICEF,) to ensure availability of food for the management of acute malnutrition at community and health facility levels in HZs with documented high levels of acute malnutrition (Lodja, Lomela and Luiza).
Activity 8	**IMCI**

8.1	Train 24 health care providers in the clinical aspects of IMCI in Dekese "landlocked" Health Zone as a priority among the 6 HZs remaining to train.
8.2	Coordinate with MOH communications focal point to conduct regular media briefings on IMCI in each district/ coordination office.
8.3	Assess functionality of 447 community case management sites that were created by MCHIP in 49 HZ out of 80 IHP HZ.
8.4	Carry out a revitalization plan of CCM sites that are not functional and propose a realistic scale- up plan.
Activity 9	**Family Planning**
9.1	Train all PROSANI technical staff in family planning regulations (USAID Online Course and Certification).
9.2	Distribute Tiahrt posters to place in all health facilities covered by the project; distribution of posters integrated into other activities.
9.3	Supply community distribution agents with condoms, cycle beads and FP tools including community worker book.
9.4	Explore integration of FP in CCM sites as part of CCM sites functionality assessment.
Activity 10	**Maternal and Neonatal Health**
10.1	Provide on-the-job training through supportive supervision visits and ensure inclusion and strengthening of Active Management of the Third Stage of Labor (AMSTL), essential newborn care, and other best practices related to mother, child, and neonatal health in Mwene Ditu, Kole, Bukavu and Uvira.
10.2	Provide labor and delivery supplies, including AMSTL, oxytocin, and newborn care kits. Distribution will be combined with other supplies.
10.3	Provide technical support for the follow up of health care providers trained in L&D and the reinforcement of their capacity through regular supervisory visits.
10.4	Finalize the hiring process of the IHP MNH Advisor.
10.5	Hire an international consultant (Indira) to support IHP in design Newborn health effective interventions and implementation plan and train MNH Advisor.
10.6	Train 20 health providers (4 from Panzi GRH in Bukavu and Dilala GRH in Kolwezi and 16 IHP) on KMC.
10.7	Explore feasibility of KMC in selected health centers in Panzi and Dilala HZs.
Activity 11	**Fistula Care**
11.1	Conduct needs assessment of hospitals providing fistula care i.e. Panzi, Kaziba, Uvira and Tshikaji.
11.2	Develop, finalize and sign MOUs with two HGRs out the 4 HGRs assessed.
11.3	Provide financial support to the selected 2 HGRs in providing comprehensive fistula care to women with obstetrical fistula.
Activity 12	**Malaria**
12.1	Finalize the hiring process of the IHP Malaria Advisor.
12.2	Train health care providers on rapid tests in selected health centers that received TDRs in Luiza, Bukavu, Uvira and Kolwezi.
12.3	Develop and implement distribution plan for delivering all commodities (Nets, ACTs, and RDTs). RTDs will be distributed to the selected HCs trained.
12.4	Provide technical, logistical and financial support to HZs during ITNs campaign in Katanga and the 2 Kasaï.
Activity 13	**PMTCT**
13.1	Participate in the revision of selected PMTCT tools in collaboration with other partners (PNLS, ProVIC).
13.2	Train on the new regimen treatment and early diagnostic 100 health providers and 50 lab technicians, from Kolwezi and Kamina that have already received from PNLS sufficient quantity of ART to be used on the PMTCT new regimen.
13.3	Provide the existing 138 sites with screening kits, as well as needles, plasters, and other PMTCT supplies.
13.4	Develop and implement a training plan on universal precautions for infection prevention and hospital hygiene for general referral hospital and referral health centers in Kolwezi.

Activity 14	**Blood Safety**
14.1	Provide to selected GRHs and RHCs with biomarkers (HIV, HBs, RPR, and HCV) which are mandatory for blood safety.
14.2	Train 42 health providers and 80 peer recruiters on blood transfusion and blood screening in Bukavu in collaboration with Safe Blood for Africa.
Activity 15	**Tuberculosis**
15.1	Provide technical, logistical and financial to TB National Program in conducting data audit in Kamina and Bukavu. TB 2015 will be designing the audit protocol.
15.2	Train 140 CHWs and Clubs Damien members on DOTS and provide them IEC materials. Walungu, Minova, Kamituga are targeted because there are not enough CHWs trained (source CPLT Bukavu).
15.3	Supply health centers with PATI 4 training modules to all selected Tuberculosis Testing and Treatment Center (CSDT , CST) as a reference for providers.
15.4	Inventory and equip laboratories with microscopes, reagents, and other laboratory consumable supplies based on the needs assessment, including related coaching in supervisory visits.
15.5	Collect, in collaboration with the Provincial Coordinations of the Integrated Anti-Tuberculosis Program (PATI), samples from TB clients whose treatment were unsuccessful and send them for analysis to the National program against Tuberculosis Laboratory in Kinshasa.
Activity 16	**WASH**
16.1	Participate in a national workshop to review existing materials and strategies used to promote clean village approach in coordination with other implementing organizations (UNICEF, IRC, ENVIDEV, ECC, etc).
16.2	Conduct training on WASH management for 20 communities selected in each of the 8 IHP coordination offices as result of the WASH need assessment conducted last quarter.
16.3	Organization of TOTs for 45 persons on technical skills for the construction of WASH Equipments: from HZs where 20 priority communities were selected.
16.4	Train at least 400 local artisans on WASH hardware building and maintenance for HCs and communities.
16.5	Train of trainers on the 16 PROSANI BCC-WASH specialists.
16.6	Construct at least 100 water points at communities' level and 2000 latrines.
16.7	Supply at least 20 FOSA with the WASH minimum package (water container + tap, Aqua tabs, clean water test kits, etc).
Activity 17	**PBF**
17.1	Develop PBF procedures manual.
17.2	Organize an orientation meeting on IHP PBF model for with USAID and other implementing agencies funded by USAID (HS 20/20, MCHIP, PROVIC, C-Change, etc.).
17.3	Conduct preparation activities prior implementation.
17.3.1	Identify and Select HZ and health centers.
17.3.2	Organize orientation meeting for MOH (DEP, 5th Direction, etc) and conduct a PBF ToT for respectively 4 persons at central, 8 at provincial and 12 at district levels for 14 days.
17.3.3	Conduct training for PBF providers from 8 HZ for 3 days and identify targeted population
17.4	Initiate and finalize contracts with health zones and local community organizations (8 HZ, 8 GRH, 160 HC and 160 HC and 16 community organizations) and send them to USAID for approval.
Activity 18	**BCC & Community Mobilization**
18.1	Work with CODESAs to strengthen two-way community-facility referral networks
18.2	Adapt the reference/counter-reference tools between the health facilities and the communities, ensuring adequate revision of diagnostic standards. Make copies of the reference/counter-reference tools in the community care sites that exist in the 80 HZs and disseminate them.

18.3	Finalize assessment of operational and functional CODESAs' in 40 HZs.
18.4	Organize 5-day one TOT for 50 for CODESA trainers in Mwene Ditu and Luiza
18.5	Train 120 selected number of motivated and organized CODESAs in role and importance in HZ system, management, advocacy and community mobilization, targeting 10 selected HZs in year one in Mwene Ditu.
18.6	Assess feasibility of community champion strategy in selected communities in HZs implementing PBF.
18.7	Initiate ETL pilot activities in Bukavu.
	Component 2, IR 4 *(Health sector leadership and governance in target provinces improved):*
Activity 19	**Policies, norms and standards**
19.1	Provide technical, logistical and financial support to the MOH to finalize/print/disseminate existing health policy documents, including norms, standards, and policies relevant to IHP program implementation (Essential drug list, *Ordinogrammes*, IMCI, Training tools, etc).
19.2	Provide technical and financial support to monthly monitoring meetings at both Health Area and BCZ levels to share information, analyze and validate data collection (one monthly meeting at each level).
	Project Management:
Activity 20	**Operations**
20.1	Ensure ongoing operations, management, and monitoring support of IHP and harmonize procedures across IHP coordination offices.
20.2	Design grants for HZs, DPS and districts and request USAID approval.
20.3	Ensure all 80 HZs receive financial and in kind support at least on a monthly basis.
20.4	Complete recruitment and train new staff at central and coordination offices levels.
20.5	Initiate the procurement of 5 vehicles (SUV 4X4) and 2 boats to facilitate for supervision activities of HZs, HCs and HGRs.
Activity 21	**Branding and Marking**
21.1	Implement USAID-approved branding and marking plan.
21.2	Train All IHP staff in branding and marking.
21.3	Display IHP signage in IHP coordination offices and supported HZs and health facilities.
21.4	Organize IHP official introduction to MOH authorities at all levels.
21.5	Relocate Kolwezi office to make it visible.
Activity 22	**M&E**
22.1	Finalize baseline study and the PMP.
22.2	Produce Quarterly and prepare Annual Reports for USAID/DRC.
22.3	Complete IHP Success Stories to submit with Quarterly and Annual Report**s.**
Activity 23	**Planning**
23.1	Prepare IHP work plan for year 2.
23.2	Organize a work planning workshop.

Annex 4

APPENDIX 4: PHARMACEUTICALS DELIVERED DURING Q4PY1

Pharmaceuticals delivered to CEDIMEK/Kolwezi

Description	Quantity
Lamivudine 150 mg + Zidovudine 300 mg + Nevirapine 200 mg	193 bte x 60 tab
Effavirenz 600 mg	34 bte X 30 tab
Diazepam 5 mg	15 bte x 1000 tab
Diazepam 10 mg/2 ml	109 bte X 100 amp
Phenobarbital 100 mg/tab	3 bte x 1000 tab
Hydrocortisone 100 mg (AS sodium succinate) inj.	171 bte X 50 VLS
Ketamine 50 mg/ml, 10 ml inj	21 x 25 VLS
Lidocaïne HCl 2% 20ml/inj	104 x 10 VLS
Lidocaïne HCl 5% + dextrose 7,5 % 2 ml spinal inj.	4 x 100 amp
Metoclopramide HCl 10 mg/2 ml, inj.	30 x 100 amp.
Salbutamol 0,5 mg/ml, 1 ml inj.	15 x 100 amp.
Magnesium sulphate 50 % 20 ml inj	20 X 10 VLS
Sodium dichloroisocyanurate 1,67 g (NaDCC) tab	225 x 200 tab
Dextrose 50 %/ 50 ml/inj	38 x 20 VLS
Seringue à Insuline disp. 1ml + 26 G ndl 100iu/ml	5 x 100 pce
Catheter Foley Ch 14 ballon 5-15 ml sterile	38 x 10 pce
Catheter Foley Ch 16 ballon 5-15 ml sterile	38 x 10 pce
Scalp vein infusion set 21G	15 x 100 pce
Scalp vein infusion set 23G	30 x 100 pce
Gants d'examen large, médium	36 x 20 x 100 pce
Acetylsalicylic acid 500 mg, tab	139 x 1000 tab
Folic acid 5 mg , tab	15 x 1000 tab
Cloxacillin 250 mg cap	30 x 1000 tab
Cimetidine 200 mg, tab	20 x 500 tab
Digoxin 0,25 mg tab	36 x 28 tab
Enalapril maleate 5 mg	100 x 100 tab
Erythromycin 250 mg	10 x 1000 tab
Glibenclamide 5 mg tab	10 x 1000 tab
Griseofulvin 500 mg tab	6 x 1000 tab
Hyoscine butylbromide 10 mg tab	70 x 1000 tab
Nystatin 500,000 IU oral coated tab	250 x 100 tab
Atropine sulphate, 1mg/ml, 1 ml inj	15 x 100 amp.
Chloramphenicol 1 g (as sodium succinate) inj	40 x 50 VLS
Dexamethasone sodium phosphate 5 mg/ml, inj	10 x 100 amp
Digoxin 0,5 mg/2 ml	5 x 100 amp
Epinephrine (adrenaline) 1mg/ml, 1 ml inj	4 x 100 amp
Furosemide 20 mg/2ml inj	30 x 100 amp.
Cefixime 200 mg	25 x 100 tab
Test de grossesse	15 x 100 tst
Azithromycine 250	185 x 6 cap
Pipette pasteur 150 mm 3 ml graduer	10 x 500 pce
Gentamycin 80 mg/ 2 ml inj	150 x 100 amp
Zidovudine 300 mg	1500 x 60 tab
Bloodgroup anti A 200 tst monoclonal 10ml	18 x 10 VLS
Bloodgroup anti A/B 200 tst monoclonal 10ml	18 x 10 VLS

Bloodgroup anti B 200 tst monoclonal 10ml	18 x 10 VLS
Bloodgroup anti D 200 tst monoclonal 10ml	18 x 10 VLS
Test de groupage sanguin, anti A, monoclonal, 10ml, Unité, 10 Fl	300 x 10 Vls
Test de groupage sanguin, anti AB, monoclonal, 10ml, Unité, 10 FL	300 x 10 Vls
Test de groupage sanguin, anti B, monoclonal, 10ml, Unité, 10 FL	300 x 10 Vls
Test de groupage sanguin, anti D, monoclonal, 10ml, Unité, 10 FL	300 x 10 Vls
Nevirapine Oral, 10 mg/100 ml, PC	648 X 1 pce
Test de grossesse(RST/HCG),Flacon 100 bandelettes	20 x 100 pce
Automatic pipette adjustable 10-100 ul	6 x 500 pce
Tips f. automatic pipette blue 100-1000ul, eppendort(Tips, pqt 500 PC), Bleu	6000 x 1
Test tubes, glass, 160 x16mm, 100 Pc	800
Infusion giving set with (4x100 pc)	2400
Turk solution acet.acid/gentianviolet, PC	20
Blood counting chamber Neubauer (Improved)	10
Pipette pasteur 150mm 3 ml graduated plastic, 500 PC	24000
Zidovudine 300 mg	320 x 60 tab
Lamivudine 150 mg + Zidovudine 300 mg	185 x 60 tab
Névirapine 200 mg	9 x 60 tab

Pharmaceuticals delivered to FODESA/Lodja

Description	Quantity
Diazepam 5 mg	15 bte x 1000 tab
Diazepam 10 mg/2 ml	109 bte X 100 amp
Phenobarbital 100 mg/tab	3 bte x 1000 tab
Lamivudine 150 mg + Zidovudine 300 mg + Nevirapine 200 mg	193 bte x 60 tab
Effavirenz 600 mg	34 bte X 30 tab
Zidovudine 300 mg	1500 x 60 tab
Zidovudine 300 mg	320 x 60 tab
Lamivudine 150 mg + Zidovudine 300 mg	185 x 60 tab
Névirapine 200 mg	9 x 60 tab
Bloodgroup anti A 200 tst monoclonal 10ml	18 x 10 VLS
Bloodgroup anti A/B 200 tst monoclonal 10ml	18 x 10 VLS
Bloodgroup anti B 200 tst monoclonal 10ml	18 x 10 VLS
Bloodgroup anti D 200 tst monoclonal 10ml	18 x 10 VLS
Hydrocortisone 100 mg (AS sodium succinate) inj.	171 bte X 50 VLS
Ketamine 50 mg/ml, 10 ml inj	21 x 25 VLS
Lidocaïne HCl 2% 20ml/inj	104 x 10 VLS
Lidocaïne HCl 5% + dextrose 7,5 % 2 ml spinal inj.	4 x 100 amp
Metoclopramide HCl 10 mg/2 ml, inj.	30 x 100 amp.
Salbutamol 0,5 mg/ml, 1 ml inj.	15 x 100 amp.
Magnesium sulphate 50 % 20 ml inj	20 X 10 VLS
Sodium dichloroisocyanurate 1,67 g (NaDCC) tab	225 x 200 tab
Dextrose 50 %/ 50 ml/inj	38 x 20 VLS
Seringue à Insuline disp. 1ml + 26 G ndl 100iu/ml	5 x 100 pce
Catheter Foley Ch 14 ballon 5-15 ml sterile	38 x 10 pce
Catheter Foley Ch 16 ballon 5-15 ml sterile	38 x 10 pce
Scalp vein infusion set 21G	15 x 100 pce

Scalp vein infusion set 23G	30 x 100 pce
Gants d'examen large, médium	36 x 20 x 100 pce
Acetylsalicylic acid 500 mg, tab	139 x 1000 tab
Folic acid 5 mg , tab	15 x 1000 tab
Cloxacillin 250 mg cap	30 x 1000 tab
Cimetidine 200 mg, tab	20 x 500 tab
Digoxin 0,25 mg tab	36 x 28 tab
Enalapril maleate 5 mg	100 x 100 tab
Erythromycin 250 mg	10 x 1000 tab
Glibenclamide 5 mg tab	10 x 1000 tab
Griseofulvin 500 mg tab	6 x 1000 tab
Hyoscine butylbromide 10 mg tab	70 x 1000 tab
Nystatin 500,000 IU oral coated tab	250 x 100 tab
Atropine sulphate, 1mg/ml, 1 ml inj	15 x 100 amp.
Chloramphenicol 1 g (as sodium succinate) inj	40 x 50 VLS
Dexamethasone sodium phosphate 5 mg/ml, inj	10 x 100 amp
Digoxin 0,5 mg/2 ml	5 x 100 amp
Epinephrine (adrenaline) 1mg/ml, 1 ml inj	4 x 100 amp
Furosemide 20 mg/2ml inj	30 x 100 amp.
Cefixime 200 mg	19 x 100 tab
Test de grossesse	13 x 100 tst
Azithromycine 250	185 x 6 cap
Pipette pasteur 150 mm 3 ml graduer	10 x 500 pce
Gentamycin 80 mg/ 2 ml inj	150 x 100 amp
Test de groupage sanguin, anti A, monoclonal, 10ml, Unité, 10 Fl	100 X 10 VLS
Test de groupage sanguin, anti AB, monoclonal, 10ml, Unité, 10 FL	100 X 10 VLS
Test de groupage sanguin, anti B, monoclonal, 10ml, Unité, 10 FL	100 X 10 VLS
Test de groupage sanguin, anti D, monoclonal, 10ml, Unité, 10 FL	100 X 10 VLS
Nevirapine Oral, 10 mg/100 ml, PC	81 X 1 pce
Test de grossesse(RST/HCG),Flacon 100 bandelettes	5 x 100 pce
Automatic pipette adjustable 10-100 ul	2 x 1pce
Tips f. automatic pipette blue 100-1000ul, eppendort(Tips, pqt 500 PC), Bleu	2000
Test tubes, glass, 160 x16mm, 100 Pc	800
Infusion giving set with (4x100 pc)	800
Turk solution acet.acid/gentianviolet, PC	10
Blood counting chamber Neubauer (Improved)	8
Pipette pasteur 150mm 3 ml graduated plastic, 500 PC	3000

Pharmaceuticals delivered to CADMEKO/Mbuji Mayi

Description	**Quantity**
Diazepam 5 mg	15 bte x 1000 tab
Diazepam 10 mg/2 ml	109 bte X 100 amp
Phenobarbital 100 mg/tab	3 bte x 1000 tab
Lamivudine 150 mg + Zidovudine 300 mg + Nevirapine 200 mg	301 bte x 60 tab
Effavirenz 600 mg	34 bte X 30 tab
Bloodgroup anti A 200 tst monoclonal 10ml	18 x 10 VLS
Bloodgroup anti A/B 200 tst monoclonal 10ml	18 x 10 VLS
Bloodgroup anti B 200 tst monoclonal 10ml	18 x 10 VLS

Bloodgroup anti D 200 tst monoclonal 10ml	18 x 10 VLS
Acetylsalicylic acid 500 mg, tab	60 x 1000 tab
Griseofulvin 500 mg tab	3 x 1000 tab
Hyoscine butylbromide 10 mg tab	30 x 1000 tab
Nystatin 500,000 IU oral coated tab	107 x 100 tab
Water for injection	680 x 50 amp
Epinephrine (adrenaline) 1mg/ml, 1 ml inj	4 x 100 amp
Ketamine 50 mg/ml, 10 ml inj	9 x 25 VLS
Lidocaïne HCI 5% + dextrose 7,5 % 2 ml spinal inj.	2 x 100 amp
Pregnancy test hCG strips 2,5 mm	13 x test
Cefixime 200 mg	19 x 100 tab
Azithromycine 250	185 x 6 cap
Pipette pasteur 150 mm 3 ml graduer	10 x 500 pce
Hydrocortisone 100 mg (AS sodium succinate) inj.	171 bte X 50 VLS
Ketamine 50 mg/ml, 10 ml inj	21 x 25 VLS
Lidocaïne HCI 2% 20ml/inj	104 x 10 VLS
Lidocaïne HCI 5% + dextrose 7,5 % 2 ml spinal inj.	4 x 100 amp
Metoclopramide HCI 10 mg/2 ml, inj.	30 x 100 amp.
Salbutamol 0,5 mg/ml, 1 ml inj.	15 x 100 amp.
Magnesium sulphate 50 % 20 ml inj	20 X 10 VLS
Sodium dichloroisocyanurate 1,67 g (NaDCC) tab	225 x 200 tab
Dextrose 50 %/ 50 ml/inj	38 x 20 VLS
Seringue à Insuline disp. 1ml + 26 G ndl 100iu/ml	5 x 100 pce
Catheter Foley Ch 14 ballon 5-15 ml sterile	38 x 10 pce
Catheter Foley Ch 16 ballon 5-15 ml sterile	38 x 10 pce
Scalp vein infusion set 21G	15 x 100 pce
Scalp vein infusion set 23G	30 x 100 pce
Gants d'examen large, médium	36 x 20 x 100 pce
Acetylsalicylic acid 500 mg, tab	60 x 1000 tab
Folic acid 5 mg , tab	15 x 1000 tab
Cloxacillin 250 mg cap	30 x 1000 tab
Cimetidine 200 mg, tab	20 x 500 tab
Digoxin 0,25 mg tab	36 x 28 tab
Enalapril maleate 5 mg	100 x 100 tab
Erythromycin 250 mg	10 x 1000 tab
Glibenclamide 5 mg tab	10 x 1000 tab
Griseofulvin 500 mg tab	3 x 1000 tab
Hyoscine butylbromide 10 mg tab	30 x 1000 tab
Nystatin 500,000 IU oral coated tab	107 x 100 tab
Atropine sulphate, 1mg/ml, 1 ml inj	15 x 100 amp.
Chloramphenicol 1 g (as sodium succinate) inj	40 x 50 VLS
Dexamethasone sodium phosphate 5 mg/ml, inj	10 x 100 amp
Digoxin 0,5 mg/2 ml	5 x 100 amp
Epinephrine (adrenaline) 1mg/ml, 1 ml inj	4 x 100 amp
Furosemide 20 mg/2ml inj	30 x 100 amp.
Gentamycin 80 mg/ 2 ml inj	150 x 100 amp
Cefixime 200 mg	19 x 100 tab
Test de grossesse	13 x 100 tst

Azithromycine 250	185 x 6 cap
Pipette pasteur 150 mm 3 ml graduer	10 x 500 pce
Zidovudine 300 mg	2237 x 60 tab
Zidovudine 300 mg	320 x 60 tab
Lamivudine 150 mg + Zidovudine 300 mg	185 x 60 tab
Névirapine 200 mg	9 x 60 tab

Pharmaceuticals delivered to BDOM/Bukavu

Description	**Quantity**
Diazepam 5 mg	15 bte x 1000 tab
Diazepam 10 mg/2 ml	109 bte X 100 amp
Phenobarbital 100 mg/tab	3 bte x 1000 tab
Lamivudine 150 mg + Zidovudine 300 mg + Nevirapine 200 mg	301 bte x 60 tab
Effavirenz 600 mg	34 bte X 30 tab
Lamivudine 150 mg + Zidovudine 300 mg + Nevirapine 200 mg	301 bte x 60 tab
Effavirenz 600 mg	34 bte X 30 tab
Bloodgroup anti A 200 tst monoclonal 10ml	18 x 10 VLS
Bloodgroup anti A/B 200 tst monoclonal 10ml	18 x 10 VLS
Bloodgroup anti B 200 tst monoclonal 10ml	18 x 10 VLS
Bloodgroup anti D 200 tst monoclonal 10ml	18 x 10 VLS
Acetylsalicylic acid 500 mg, tab	60 x 1000 tab
Folic acid 5 mg , tab	15 x 1000 tab
Cloxacillin 250 mg cap	30 x 1000 tab
Cimetidine 200 mg, tab	20 x 500 tab
Digoxin 0,25 mg tab	36 x 28 tab
Enalapril maleate 5 mg	100 x 100 tab
Erythromycin 250 mg	10 x 1000 tab
Glibenclamide 5 mg tab	10 x 1000 tab
Griseofulvin 500 mg tab	3 x 1000 tab
Hyoscine butylbromide 10 mg tab	30 x 1000 tab
Nystatin 500,000 IU oral coated tab	107 x 100 tab
Atropine sulphate, 1mg/ml, 1 ml inj	15 x 100 amp.
Chloramphenicol 1 g (as sodium succinate) inj	40 x 50 VLS
Dexamethasone sodium phosphate 5 mg/ml, inj	10 x 100 amp
Digoxin 0,5 mg/2 ml	5 x 100 amp
Epinephrine (adrenaline) 1mg/ml, 1 ml inj	4 x 100 amp
Furosemide 20 mg/2ml inj	30 x 100 amp.
Gentamycin 80 mg/ 2 ml inj	150 x 100 amp
Cefixime 200 mg	19 x 100 tab
Test de grossesse	13 x 100 tst
Azithromycine 250	185 x 6 cap
Pipette pasteur 150 mm 3 ml graduer	10 x 500 pce
Zidovudine 300 mg	3120 x 60 tab
Acetylsalicylic acid 500 mg, tab	139 x 1000 tab
Folic acid 5 mg , tab	15 x 1000 tab
Cloxacillin 250 mg cap	30 x 1000 tab
Cimetidine 200 mg, tab	20 x 500 tab

Digoxin 0,25 mg tab	36 x 28 tab
Enalapril maleate 5 mg	100 x 100 tab
Erythromycin 250 mg	10 x 1000 tab
Glibenclamide 5 mg tab	10 x 1000 tab
Griseofulvin 500 mg tab	6 x 1000 tab
Hyoscine butylbromide 10 mg tab	70 x 1000 tab
Nystatin 500,000 IU oral coated tab	250 x 100 tab
Atropine sulphate, 1mg/ml, 1 ml inj	15 x 100 amp.
Chloramphenicol 1 g (as sodium succinate) inj	40 x 50 VLS
Dexamethasone sodium phosphate 5 mg/ml, inj	10 x 100 amp
Digoxin 0,5 mg/2 ml	5 x 100 amp
Epinephrine (adrenaline) 1mg/ml, 1 ml inj	4 x 100 amp
Furosemide 20 mg/2ml inj	30 x 100 amp.
Gentamycin 80 mg/ 2 ml inj	150 x 100 amp
Hydrocortisone 100 mg	171 x 50 VLS
Ketamine 50 mg/ml, 10 ml	21 x 25 VLS
Lidocaine HCl 2% 20 ml inj	104 x 10 VLS
Lidocaine HCl 5%+dextrose 7,5 % 2 ml spiral inj	4 x 100 amp
Metoclopramide HCl 10 mg/2ml inj	4 x 100 amp.
Salbutamol 0,5 mg/ml, 1 ml, inj	30 x 100 amp.
Magnesium sulphate 50 % 20 ml inj	20 x 10 VLS
Dextrose 50 % 50 ml	38 x 20 VLS
Syringe insulin disp. 1ml+26G ndl	5 x 100 pce
Catheter Foley ch14 ballon 5-15ml sterile	38 x 10 pce
Catheter Foley ch16 ballon 5-15ml sterile	38 x 10 pce
Scap vein infusion set 21G	15 x 100 pce
Scap vein infusion set 23G	30 x 100 pce
Gants d'examen, latex, medium	36 x 20 x 100 pce
Zidovudine 300 mg	320 x 60 tab
Lamivudine 150 mg + Zidovudine 300 mg	185 x 60 tab
Névirapine 200 mg	9 x 60 tab

Pharmaceuticals delivered to CEPAC/Bukavu

Description	**Quantity**
Diazepam 5 mg	15 bte x 1000 tab
Diazepam 10 mg/2 ml	109 bte X 100 amp
Phenobarbital 100 mg/tab	3 bte x 1000 tab
Lamivudine 150 mg + Zidovudine 300 mg + Nevirapine 200 mg	301 bte x 60 tab
Effavirenz 600 mg	34 bte X 30 tab
Bloodgroup anti A 200 tst monoclonal 10ml	18 x 10 VLS
Bloodgroup anti A/B 200 tst monoclonal 10ml	18 x 10 VLS
Bloodgroup anti B 200 tst monoclonal 10ml	18 x 10 VLS
Bloodgroup anti D 200 tst monoclonal 10ml	18 x 10 VLS
Acetylsalicylic acid 500 mg, tab	60 x 1000 tab
Folic acid 5 mg , tab	15 x 1000 tab
Cloxacillin 250 mg cap	30 x 1000 tab
Cimetidine 200 mg, tab	20 x 500 tab

Digoxin 0,25 mg tab	36 x 28 tab
Enalapril maleate 5 mg	100 x 100 tab
Erythromycin 250 mg	10 x 1000 tab
Glibenclamide 5 mg tab	10 x 1000 tab
Griseofulvin 500 mg tab	3 x 1000 tab
Hyoscine butylbromide 10 mg tab	30 x 1000 tab
Nystatin 500,000 IU oral coated tab	107 x 100 tab
Water for injection 10 ml	680 x 50 amp
Lidocaine HCl 5%+dextrose 7,5 % 2 ml spiral inj	2 x 100 amp
Atropine sulphate, 1mg/ml, 1 ml inj	15 x 100 amp.
Chloramphenicol 1 g (as sodium succinate) inj	40 x 50 VLS
Dexamethasone sodium phosphate 5 mg/ml, inj	10 x 100 amp
Ketamine 50 mg/ml, 10 ml	9 x 25 VLS
Digoxin 0,5 mg/2 ml	5 x 100 amp
Epinephrine (adrenaline) 1mg/ml, 1 ml inj	4 x 100 amp
Furosemide 20 mg/2ml inj	30 x 100 amp.
Gentamycin 80 mg/ 2 ml inj	150 x 100 amp
Cefixime 200 mg	19 x 100 tab
Test de grossesse	13 x 100 tst
Azithromycine 250	185 x 6 cap
Pipette pasteur 150 mm 3 ml graduer	10 x 500 pce
Zidovudine 300 mg	3120 x 60 tab
Acetylsalicylic acid 500 mg, tab	139 x 1000 tab
Folic acid 5 mg , tab	15 x 1000 tab
Cloxacillin 250 mg cap	30 x 1000 tab
Cimetidine 200 mg, tab	20 x 500 tab
Digoxin 0,25 mg tab	36 x 28 tab
Enalapril maleate 5 mg	100 x 100 tab
Erythromycin 250 mg	10 x 1000 tab
Glibenclamide 5 mg tab	10 x 1000 tab
Griseofulvin 500 mg tab	6 x 1000 tab
Hyoscine butylbromide 10 mg tab	70 x 1000 tab
Nystatin 500,000 IU oral coated tab	250 x 100 tab
Atropine sulphate, 1mg/ml, 1 ml inj	15 x 100 amp.
Chloramphenicol 1 g (as sodium succinate) inj	40 x 50 VLS
Dexamethasone sodium phosphate 5 mg/ml, inj	10 x 100 amp
Digoxin 0,5 mg/2 ml	5 x 100 amp
Epinephrine (adrenaline) 1mg/ml, 1 ml inj	4 x 100 amp
Furosemide 20 mg/2ml inj	30 x 100 amp.
Gentamycin 80 mg/ 2 ml inj	150 x 100 amp
Hydrocortisone 100 mg	171 x 50 VLS
Ketamine 50 mg/ml, 10 ml	21 x 25 VLS
Lidocaine HCl 2% 20 ml inj	104 x 10 VLS
Lidocaine HCl 5%+dextrose 7,5 % 2 ml spiral inj	4 x 100 amp
Metoclopramide HCl 10 mg/2ml inj	30 x 100 amp.
Salbutamol 0,5 mg/ml, 1 ml, inj	15 x 100 amp.
Magnesium sulphate 50 % 20 ml inj	20 x 10 VLS
Dextrose 50 % 50 ml	38 x 20 VLS

Syringe insulin disp. 1ml+26G ndl	5 x 100 pce
Catheter Foley ch14 ballon 5-15ml sterile	38 x 10 pce
Catheter Foley ch16 ballon 5-15ml sterile	38 x 10 pce
Scap vein infusion set 21G	15 x 100 pce
Scap vein infusion set 23G	30 x 100 pce
Gants d'examen, latex, medium	36 x 20 x 100 pce
Zidovudine 300 mg	320 x 60 tab
Lamivudine 150 mg + Zidovudine 300 mg	185 x 60 tab
Névirapine 200 mg	9 x 60 tab

Pharmaceuticals delivered to APAMESK/Bukavu

Description	Quantity
Diazepam 5 mg	15 bte x 1000 tab
Diazepam 10 mg/2 ml	109 bte X 100 amp
Phenobarbital 100 mg/tab	3 bte x 1000 tab
Lamivudine 150 mg + Zidovudine 300 mg + Nevirapine 200 mg	301 bte x 60 tab
Effavirenz 600 mg	34 bte X 30 tab
Zidovudine 300 mg	3120 x 60 tab
Bloodgroup anti A 200 tst monoclonal 10ml	18 x 10 VLS
Bloodgroup anti A/B 200 tst monoclonal 10ml	18 x 10 VLS
Bloodgroup anti B 200 tst monoclonal 10ml	18 x 10 VLS
Bloodgroup anti D 200 tst monoclonal 10ml	18 x 10 VLS
Acetylsalicylic acid 500 mg, tab	60 x 1000 tab
Folic acid 5 mg , tab	15 x 1000 tab
Cloxacillin 250 mg cap	30 x 1000 tab
Cimetidine 200 mg, tab	20 x 500 tab
Digoxin 0,25 mg tab	36 x 28 tab
Enalapril maleate 5 mg	100 x 100 tab
Erythromycin 250 mg	10 x 1000 tab
Glibenclamide 5 mg tab	10 x 1000 tab
Griseofulvin 500 mg tab	3 x 1000 tab
Hyoscine butylbromide 10 mg tab	30 x 1000 tab
Nystatin 500,000 IU oral coated tab	107 x 100 tab
Water for injection 10 ml	680 x 50 amp
Lidocaine HCl 5%+dextrose 7,5 % 2 ml spiral inj	2 x 100 amp
Atropine sulphate, 1mg/ml, 1 ml inj	15 x 100 amp.
Chloramphenicol 1 g (as sodium succinate) inj	40 x 50 VLS
Dexamethasone sodium phosphate 5 mg/ml, inj	10 x 100 amp
Ketamine 50 mg/ml, 10 ml	9 x 25 VLS
Digoxin 0,5 mg/2 ml	5 x 100 amp
Epinephrine (adrenaline) 1mg/ml, 1 ml inj	4 x 100 amp
Furosemide 20 mg/2ml inj	30 x 100 amp.
Gentamycin 80 mg/ 2 ml inj	150 x 100 amp
Cefixime 200 mg	19 x 100 tab
Test de grossesse	13 x 100 tst
Azithromycine 250	185 x 6 cap
Pipette pasteur 150 mm 3 ml graduer	10 x 500 pce

Acetylsalicylic acid 500 mg, tab	139 x 1000 tab
Folic acid 5 mg , tab	15 x 1000 tab
Cloxacillin 250 mg cap	30 x 1000 tab
Cimetidine 200 mg, tab	20 x 500 tab
Digoxin 0,25 mg tab	36 x 28 tab
Enalapril maleate 5 mg	100 x 100 tab
Erythromycin 250 mg	10 x 1000 tab
Glibenclamide 5 mg tab	10 x 1000 tab
Griseofulvin 500 mg tab	6 x 1000 tab
Hyoscine butylbromide 10 mg tab	70 x 1000 tab
Nystatin 500,000 IU oral coated tab	250 x 100 tab
Atropine sulphate, 1mg/ml, 1 ml inj	15 x 100 amp.
Chloramphenicol 1 g (as sodium succinate) inj	40 x 50 VLS
Dexamethasone sodium phosphate 5 mg/ml, inj	10 x 100 amp
Digoxin 0,5 mg/2 ml	5 x 100 amp
Epinephrine (adrenaline) 1mg/ml, 1 ml inj	4 x 100 amp
Furosemide 20 mg/2ml inj	30 x 100 amp.
Gentamycin 80 mg/ 2 ml inj	150 x 100 amp
Hydrocortisone 100 mg	171 x 50 VLS
Ketamine 50 mg/ml, 10 ml	21 x 25 VLS
Lidocaine HCI 2% 20 ml inj	104 x 10 VLS
Lidocaine HCI 5%+dextrose 7,5 % 2 ml spiral inj	4 x 100 amp
Metoclopramide HCI 10 mg/2ml inj	4 x 100 amp.
Salbutamol 0,5 mg/ml, 1 ml, inj	30 x 100 amp.
Magnesium sulphate 50 % 20 ml inj	20 x 10 VLS
Dextrose 50 % 50 ml	38 x 20 VLS
Syringe insulin disp. 1ml+26G ndl	5 x 100 pce
Catheter Foley ch14 ballon 5-15ml sterile	38 x 10 pce
Catheter Foley ch16 ballon 5-15ml sterile	38 x 10 pce
Scap vein infusion set 21G	15 x 100 pce
Scap vein infusion set 23G	30 x 100 pce
Gants d'examen, latex, medium	36 x 20 x 100 pce
Test de groupage sanguin, anti A, monoclonal, 10ml, Unité, 10 Fl	600
Test de groupage sanguin, anti AB, monoclonal, 10ml, Unité, 10 FL	600
Test de groupage sanguin, anti B, monoclonal, 10ml, Unité, 10 FL	600
Test de groupage sanguin, anti D, monoclonal, 10ml, Unité, 10 FL	600
Nevirapine Oral, 10 mg/100 ml, PC	810
Test de grossesse(RST/HCG),Flacon 100 bandelettes	55
Hepatitis C rapid test HCVSpot/HCVScan, 100 test	100
Hepatitis B HBsAg Determine, 100 test	100
Automatic pipette adjustable 10-100 ul	7
Tips f. automatic pipette blue 100-1000ul, eppendort(Tips, pqt 500 PC), Bleu	6000
Test tubes, glass, 160 x16mm, 100 Pc	1200
Infusion giving set with (4x100 pc)	9200
Turk solution acet.acid/gentianviolet, PC	40
Blood counting chamber Neubauer (Improved)	20
Pipette pasteur 150mm 3 ml graduated plastic, 500 PC	27000
Zidovudine 300 mg	320 x 60 tab

Lamivudine 150 mg + Zidovudine 300 mg	185 x 60 tab
Névirapine 200 mg	9 x 60 tab

Pharmaceuticals delivered to CEDIMEK/Kamina

Description	Quantity
Diazepam 5 mg	15 bte x 1000 tab
Diazepam 10 mg/2 ml	109 bte X 100 amp
Phenobarbital 100 mg/tab	3 bte x 1000 tab
Lamivudine 150 mg + Zidovudine 300 mg + Nevirapine 200 mg	304 x 60 tab
Effavirenz 600 mg	34 bte X 30 tab
Bloodgroup anti A 200 tst monoclonal 10ml	18 x 10 VLS
Bloodgroup anti A/B 200 tst monoclonal 10ml	18 x 10 VLS
Bloodgroup anti B 200 tst monoclonal 10ml	18 x 10 VLS
Bloodgroup anti D 200 tst monoclonal 10ml	18 x 10 VLS
Hydrocortisone 100 mg (AS sodium succinate) inj.	171 bte X 50 VLS
Ketamine 50 mg/ml, 10 ml inj	21 x 25 VLS
Lidocaïne HCl 2% 20ml/inj	104 x 10 VLS
Lidocaïne HCl 5% + dextrose 7,5 % 2 ml spinal inj.	4 x 100 amp
Metoclopramide HCl 10 mg/2 ml, inj.	30 x 100 amp.
Salbutamol 0,5 mg/ml, 1 ml inj.	15 x 100 amp.
Magnesium sulphate 50 % 20 ml inj	20 X 10 VLS
Sodium dichloroisocyanurate 1,67 g (NaDCC) tab	225 x 200 tab
Dextrose 50 %/ 50 ml/inj	38 x 20 VLS
Seringue à Insuline disp. 1ml + 26 G ndl 100iu/ml	5 x 100 pce
Catheter Foley Ch 14 ballon 5-15 ml sterile	38 x 10 pce
Catheter Foley Ch 16 ballon 5-15 ml sterile	38 x 10 pce
Scalp vein infusion set 21G	15 x 100 pce
Scalp vein infusion set 23G	30 x 100 pce
Gants d'examen large, médium	36 x 20 x 100 pce
Acetylsalicylic acid 500 mg, tab	60 x 1000 tab
Folic acid 5 mg , tab	15 x 1000 tab
Cloxacillin 250 mg cap	30 x 1000 tab
Cimetidine 200 mg, tab	20 x 500 tab
Digoxin 0,25 mg tab	36 x 28 tab
Enalapril maleate 5 mg	100 x 100 tab
Erythromycin 250 mg	10 x 1000 tab
Glibenclamide 5 mg tab	10 x 1000 tab
Griseofulvin 500 mg tab	3 x 1000 tab
Hyoscine butylbromide 10 mg tab	30 x 1000 tab
Nystatin 500,000 IU oral coated tab	107 x 100 tab
Atropine sulphate, 1mg/ml, 1 ml inj	15 x 100 amp.
Chloramphenicol 1 g (as sodium succinate) inj	40 x 50 VLS
Dexamethasone sodium phosphate 5 mg/ml, inj	10 x 100 amp
Digoxin 0,5 mg/2 ml	5 x 100 amp
Epinephrine (adrenaline) 1mg/ml, 1 ml inj	4 x 100 amp
Furosemide 20 mg/2ml inj	30 x 100 amp.
Gentamycin 80 mg/ 2 ml inj	150 x 100 amp

Cefixime 200 mg	19 x 100 tab
Test de grossesse	13 x 100 tst
Azithromycine 250	185 x 6 cap
Pipette pasteur 150 mm 3 ml graduer	10 x 500 pce
Zidovudine 300 mg	2500 x 60 tab
Zidovudine 300 mg	1674 x 60 tab
Lamivudine 150 mg + Zidovudine 300 mg	185 x 60 tab
Névirapine 200 mg	9 x 60 tab
Test de groupage sanguin, anti A, monoclonal, 10ml, Unité, 10 Fl	500
Test de groupage sanguin, anti AB, monoclonal, 10ml, Unité, 10 FL	500
Test de groupage sanguin, anti B, monoclonal, 10ml, Unité, 10 FL	500
Test de groupage sanguin, anti D, monoclonal, 10ml, Unité, 10 FL	500
Nevirapine Oral, 10 mg/100 ml, PC	648
Test de grossesse(RST/HCG),Flacon 100 bandelettes	33
Automatic pipette adjustable 10-100 ul	6
Tips f. automatic pipette blue 100-1000ul, eppendort(Tips, pqt 500 PC), Bleu	6000
Test tubes, glass, 160 x16mm, 100 Pc	1200
Infusion giving set with (4x100 pc)	10000
Turk solution acet.acid/gentianviolet, PC	20
Blood counting chamber Neubauer (Improved)	10
Pipette pasteur 150mm 3 ml graduated plastic, 500 PC	6000
Test de groupage sanguin, anti A, monoclonal, 10ml, Unité, 10 Fl	4462,884615
Test de groupage sanguin, anti AB, monoclonal, 10ml, Unité, 10 FL	4815,637363

Pharmaceuticals delivered to CADIMEK/Kananga

Description	**Quantity**
Diazepam 5 mg	15 bte x 1000 tab
Diazepam 10 mg/2 ml	109 bte X 100 amp
Phenobarbital 100 mg/tab	3 bte x 1000 tab
Acetylsalicylic acid 500 mg, tab	60 x 1000 tab
Folic acid 5 mg , tab	15 x 1000 tab
Cloxacillin 250 mg cap	30 x 1000 tab
Cimetidine 200 mg, tab	20 x 500 tab
Digoxin 0,25 mg tab	36 x 28 tab
Enalapril maleate 5 mg	100 x 100 tab
Erythromycin 250 mg	10 x 1000 tab
Glibenclamide 5 mg tab	10 x 1000 tab
Griseofulvin 500 mg tab	3 x 1000 tab
Hyoscine butylbromide 10 mg tab	30 x 1000 tab
Nystatin 500,000 IU oral coated tab	107 x 100 tab
Water for injection 10 ml	680 x 50 amp
Lidocaine HCl 5%+dextrose 7,5 % 2 ml spiral inj	2 x 100 amp
Atropine sulphate, 1mg/ml, 1 ml inj	15 x 100 amp.
Chloramphenicol 1 g (as sodium succinate) inj	40 x 50 VLS
Dexamethasone sodium phosphate 5 mg/ml, inj	10 x 100 amp
Ketamine 50 mg/ml, 10 ml	9 x 25 VLS
Digoxin 0,5 mg/2 ml	5 x 100 amp

Epinephrine (adrenaline) 1mg/ml, 1 ml inj	4 x 100 amp
Furosemide 20 mg/2ml inj	30 x 100 amp.
Gentamycin 80 mg/ 2 ml inj	150 x 100 amp
Cefixime 200 mg	19 x 100 tab
Test de grossesse	13 x 100 tst
Azithromycine 250	185 x 6 cap
Pipette pasteur 150 mm 3 ml graduer	10 x 500 pce
Bloodgroup anti A 200 tst monoclonal 10ml	18 x 10 VLS
Bloodgroup anti A/B 200 tst monoclonal 10ml	18 x 10 VLS
Bloodgroup anti B 200 tst monoclonal 10ml	18 x 10 VLS
Bloodgroup anti D 200 tst monoclonal 10ml	18 x 10 VLS
Lamivudine 150 mg + Zidovudine 300 mg + Nevirapine 200 mg	304 x 60 tab
Effavirenz 600 mg	34 bte X 30 tab
Zidovudine 300 mg	3120 x 60 tab
Zidovudine 300 mg	1674 x 60 tab
Lamivudine 150 mg + Zidovudine 300 mg	185 x 60 tab
Névirapine 200 mg	9 x 60 tab
Hydrocortisone 100 mg (AS sodium succinate) inj.	171 bte X 50 VLS
Ketamine 50 mg/ml, 10 ml inj	21 x 25 VLS
Lidocaïne HCl 2% 20ml/inj	104 x 10 VLS
Lidocaïne HCl 5% + dextrose 7,5 % 2 ml spinal inj.	4 x 100 amp
Metoclopramide HCl 10 mg/2 ml, inj.	30 x 100 amp.
Salbutamol 0,5 mg/ml, 1 ml inj.	15 x 100 amp.
Magnesium sulphate 50 % 20 ml inj	20 X 10 VLS
Sodium dichloroisocyanurate 1,67 g (NaDCC) tab	225 x 200 tab
Dextrose 50 %/ 50 ml/inj	38 x 20 VLS
Seringue à Insuline disp. 1ml + 26 G ndl 100iu/ml	5 x 100 pce
Catheter Foley Ch 14 ballon 5-15 ml sterile	38 x 10 pce
Catheter Foley Ch 16 ballon 5-15 ml sterile	38 x 10 pce
Scalp vein infusion set 21G	15 x 100 pce
Scalp vein infusion set 23G	30 x 100 pce
Gants d'examen large, médium	36 x 20 x 100 pce
Acetylsalicylic acid 500 mg, tab	60 x 1000 tab
Folic acid 5 mg , tab	15 x 1000 tab
Cloxacillin 250 mg cap	30 x 1000 tab
Cimetidine 200 mg, tab	20 x 500 tab
Digoxin 0,25 mg tab	36 x 28 tab
Enalapril maleate 5 mg	100 x 100 tab
Erythromycin 250 mg	10 x 1000 tab
Glibenclamide 5 mg tab	10 x 1000 tab
Griseofulvin 500 mg tab	3 x 1000 tab
Hyoscine butylbromide 10 mg tab	30 x 1000 tab
Nystatin 500,000 IU oral coated tab	107 x 100 tab
Atropine sulphate, 1mg/ml, 1 ml inj	15 x 100 amp.
Chloramphenicol 1 g (as sodium succinate) inj	40 x 50 VLS
Dexamethasone sodium phosphate 5 mg/ml, inj	10 x 100 amp
Digoxin 0,5 mg/2 ml	5 x 100 amp
Epinephrine (adrenaline) 1mg/ml, 1 ml inj	4 x 100 amp

Furosemide 20 mg/2ml inj	30 x 100 amp.
Gentamycin 80 mg/ 2 ml inj	150 x 100 amp
Cefixime 200 mg	19 x 100 tab
Test de grossesse	13 x 100 tst
Azithromycine 250	185 x 6 cap
Pipette pasteur 150 mm 3 ml graduer	10 x 500 pce
Test de groupage sanguin, anti A, monoclonal, 10ml, Unité, 10 Fl	200
Test de groupage sanguin, anti AB, monoclonal, 10ml, Unité, 10 FL	200
Test de groupage sanguin, anti B, monoclonal, 10ml, Unité, 10 FL	200
Test de groupage sanguin, anti D, monoclonal, 10ml, Unité, 10 FL	200
Nevirapine Oral, 10 mg/100 ml, PC	486
Test de grossesse(RST/HCG),Flacon 100 bandelettes	20
Automatic pipette adjustable 10-100 ul	5
Tips f. automatic pipette blue 100-1000ul, eppendort(Tips, pqt 500 PC), Bleu	6000
Test tubes, glass, 160 x16mm, 100 Pc	1200
Infusion giving set with (4x100 pc)	4000
Turk solution acet.acid/gentianviolet, PC	20
Blood counting chamber Neubauer (Improved)	10
Pipette pasteur 150mm 3 ml graduated plastic, 500 PC	6000
Hepatitis C rapid test HCVSpot/HCVScan, 100 test	100

Annex 5

APPENDIX 5: AIR SHIPMENTS IN TRANSIT PENDING CUSTOMS CLEARANCE

Destination	N° LTA / AWB/BL	Description	Number of Packages	ETA
CADIMEK KANANGA	082-13416933	Test Kit, HIV1+2(uni-gold),20 test rapid test	496	15/09/2011
		Test Kit, HIV1+2(Determine) 100 tests		
		Test Kit, HIV1+2(Doublecheck Gold) 100 tests, Rapid test		
CEDIMEK KAMINA		Test Kit , Syphillis, RPR, 250 tests		
		Test Kit, HIV1+2(uni-gold),20 test rapid test		
		Test Kit, HIV1+2(Determine) 100 tests		
		Test Kit, HIV1+2(Doublecheck Gold) 100 tests, Rapid test		
CEDMEK KOLWEZI		Test Kit, HIV1+2(uni-gold),20 test rapid test		
		Test Kit, HIV1+2(Determine) 100 tests		
		Test Kit, HIV1+2(Doublecheck Gold) 100 tests, Rapid test		
CADMEKO MBUJI MAYI		Test Kit, HIV1+2(uni-gold),20 test rapid test		
		Test Kit, HIV1+2(Determine) 100 tests		
		Test Kit, HIV1+2(Doublecheck Gold) 100 tests, Rapid test		
FODESA		Test Kit, HIV1+2(uni-gold),20 test rapid test		
		Test Kit, HIV1+2(Determine) 100 tests		
		Test Kit, HIV1+2(Doublecheck Gold) 100 tests, Rapid test		
APAMESK BUKAVU		Test Kit, HIV1+2(uni-gold),20 test rapid test		
		Test Kit, HIV1+2(Determine) 100 tests		
		Test Kit, HIV1+2(Doublecheck Gold) 100 tests, Rapid test		
BDOM BUKAVU		Test Kit, HIV1+2(uni-gold),20 test rapid test		
		Test Kit, HIV1+2(Determine) 100 tests		
		Test Kit, HIV1+2(Doublecheck Gold) 100 tests, Rapid test		
8è CEPAC BUKAVU		Test Kit, HIV1+2(uni-gold),20 test rapid test		
		Test Kit, HIV1+2(Determine) 100 tests		
		Test Kit, HIV1+2(Doublecheck Gold) 100 tests, Rapid test		
KINSHASA		Test Kit, HIV1+2(uni-gold),20 test rapid test		
		Test Kit, HIV1+2(Determine) 100 tests		
		Test Kit, HIV1+2(Doublecheck Gold) 100 tests, Rapid test		
KINSHASA	071-1650 0584	Médicaments essentiels	1238	23/09/2011
KINSHASA	071-16500606	Matériels médicals & médicaments Essentiels	1319	

Annex 6

Integrated Health Project (IHP) Year 1 International Travel and STTA Plan Oct 2010-Sept 2011 (updated 27 Oct 2011)									
#	**TECHNICAL AREA**	**SUGGESTED PERSON**	**ORG**	**Travel dates**	**INDICATIVE SCOPE OF WORK**	**Origin/ destination**	**length of trips**	**STATUS**	**NOTES**
STTA/PROJECT MANAGEMENT AND MONITORING									
Quarter 1 Oct-Dec 2010									
1	Project Management	Kristin Cooney	MSH	Nov 17-Dec 09, 2010	Start up the Integrated Health Project and assist the project transition from the Axxes Project and Leadership, Management, and Sustainability program to the Integrated Health Project, including meetings with USAID and project partners and stakeholders.	Boston/Kinshasa	23	Completed	
2	Workplanning	Jean Kagubare	MSH	Nov 28-Dec 4, 2010	Support of the start-up phase and development of the workplan for the IHP project.	Boston/Kinshasa	7	Completed	
3	Workplanning and Communication plan	Ryan Crow	OSC	Nov 28-Dec 8, 2010	Contribute to the development of the workplan and the strategic communications plan. He will also work with the Senior Staffing Specialist to recruit local	DC/Kinshasa	11	Completed	

					communications staff.				
4	Start-up operations	Christele Joseph-Pressat	MSH	Nov 28-Dec 14, 2010	Start up the DRC IHP project and assist in development of the workplan.	Boston/Kinshasa	17	Completed	
5	Project start up	Larry Michel	MSH	Nov 20-Nov 24, 2010	Start up the DRC IHP program, including meetings with USAID and project partners and stakeholders.	Boston/Kinshasa	5	Completed	
6	Recruitment	Tori Caldwell	MSH	Nov 20-Dec 4, 2010	Complete local staff recruitment for the Integrated Health Project, including training a new Human Resources Manager.	Boston/Kinshasa	15	Completed	
7	COMU	Kate Onyejekwe	MSH	Nov 17-Dec 4, 2010	Orient the Finance and Administration Specialist and set up the Kinshasa office.	Boston/Kinshasa	18	Completed	
8	Operations/Finance	Steve Morgan	MSH	Dec 08-Dec 22, 2010	Provide coverage for the Director of Finance and operations	Boston/Kinshasa	12	Completed	
Quarter 2 Jan-Mar 2011									
9	Team Orientation Workshop	John Pollock	MSH	Jan 01- Jan 15, 2011	Conduct team orientation Workshop/ Role & Clarification workshop	Boston/Kinshasa	15	Completed	

10	Recruitment	Felix Austine	MSH	Jan 04 - Feb 02, 2011	Continue the recruitment of new staff	Nigeria/Kinshasa	30	Completed	
11	Program Support	Gordana Ivkovic-Grujic	IRC	January 13-April 1, 2011	Support operational start-up of IHP project	Serbia / Kinshasa return	78	Completed	
12	WASH	Hassan Coulibaly	IRC	Jan 20-Jan 30, 2011	Support development of IHP WASH strategy	Nairobi / Kinshasa return	11	Completed	
13	M&E	Juan-Carlos Alegre	MSH	Feb 02 - Feb 12, 2011	Provide assistance in monitoring and evaluation	Boston/Kinshasa	11	Completed	
14	Security	John McKenney	MSH	Feb 5 - Feb 19, 2011	Strengthen security systems and processes in Kinshasa and regions and advise on travel security	Boston/Kinshasa	15	Completed	
15	BCC Assessment	Andrei Sinioukov	OSC	Feb 14-March 4, 2011	Conduct baseline KAP assessments for IHP target zones	Tanzania/Kinshasa	19	Completed	
16	BCC Assessment	Waverly Rennie	OSC	Feb 14-March 4, 2011	Conduct baseline KAP assessments for IHP target zones	Tanzania/Kinshasa	19	Completed	
17	Recruitment	Tori Caldwell	MSH	Feb 18 - March 6, 2011	To finalize local staff recruitment for the Integrated Health Project and offer additional orientation for the new Human Resources Manager	Boston/Kinshasa	20	Completed	
18	Program Support	Suleiman Abdiel	IRC	February 15-May 15, 2011	Supporting operational start-up of IHP project at field level	Tanzania / Kinshasa return	90	Completed	

19	Public Health	Camilo Valderama	IRC	Feb 18-February 28, 2011	Support IRC IHP start-up, review integration of Community-Driven Reconstruction approaches into IHP strategy	Pakistan / Kinshasa return	11	Cancelled	Not charged to IHP
20	Project Management	Kristin Cooney	MSH	March 06- March 19, 2011	To provide technical support and guidance /reporting assistance	Boston/Kinshasa	14	Completed	
21	Gender / GBV	Ashley Wolfington	IRC	March 15-March 30, 2011	Support development of IHP Gender / GBV strategy	New York / Kinshasa return	16	Cancelled	Not charged to IHP
22	WASH	Hassan Coulibaly	IRC	March 21-March 30, 2011	Support development of IHP WASH strategy	Nairobi / Kinshasa return	10	Completed	
23	BCC Assessment and Technical Assistance	Waverly Rennie	OSC	March 28-April 2, 2011	Provide support to communications and KAP assessments for IHP target zones	Tanzania/Kinshasa	9	Completed	
Quarter 3 Apr-Jun 2011									
24	SNIS	Nkossi Dambita	MSH	Apr 1 - Apr 16, 2011	Support PROSANI to strengthen MoH Système National de Information de la Santé (SNIS)	Maryland/Kinshasa	16	Completed	
25	PBF	Jean Kagubare	MSH	April 4-13, 2011	To support an internal PBF workshop (with USAID and other implementing agencies funded by USAID) and design the IHP PBF approach	Boston/Kinshasa	10	Completed	

26	Accounting and Finance	Donna Coulibaly	MSH	April 4 - April 17, 2011	Navigator and Quickbooks, review and strengthen Financial Systems; Support Payroll outsourcing	Nigeria/Kinshasa	14	Completed	Replaced Uder Antoine
27	Contract and Grant Management	Peter Mahoney	MSH	April 4 - April 15, 2011	Contracts/Grants Management; PBF contracting system; contractor/grantee monitoring system,	Boston/Kinshasa	14	Completed	
28	Training and Technical Assistance	TBD	OSC	April 18-September 30, 2011	Communications Capacity Building, Design and implement health communications campaigns	New York/	125	Divided among several consultants	
29	Program Support	Gordana Ivkovic-Grujic	IRC	April 10-June 10, 2011	Supporting operational start-up of IHP project	Serbia / Kinshasa return	61	Completed	
30	M&E	Juan-Carlos Alegre	MSH	May 15-20, 2011	Monitoring and evaluation; baseline study	Arlington/Kinshasa	7	Completed	
31	MNCH Activity Planning and Technical Assistance	Ciro Franco	MSH	May 10-May 26, 2011	Train MNCH advisor; strengthen planning on maternal health interventions; strengthening community care sites (CCM)	Arlington/Kinshasa	16	Completed	
32	Communications Planning and Technical Assistance	Elizabeth Walsh	MSH	May 22-June 8, 2011	Implement IHP communications plan, including building staff capacity to develop success stories	Cambridge/ Kinshasa	21	Completed	
33	Community Mobilization	Susana Galdos	Consultant	May 25-Jun 10, 2011	Conduct on-the-job training for eight IHP community mobilization specialists and	Peru/Kinshasa	15	Postponed	

					develop assessment tools for CODESAs				
34	BCC	Amelie Sow-Dia	Consultant	June 17-August 13, 2011	Review existing data; begin comprehensive baseline KAP assessment to guide BCC and other strategic communication components; work with Senior BCC Expert to develop BCC campaign materials; assist in launch of BCC activities; and initiate BCC training of local professional staff working in field offices.		42	Completed	
Quarter 4 Jul-Sep 2011									
35	BCC	Karin Veltman	OSC	01/07/2011	To work with BCC staff on new approaches in utilizing ICT; orient new local professional staff ; meet with partners on the strategic communications plan; harmonize administrative procedures	Philadelphia/ Kinshasa	14	Completed	
36	WASH consultant	Jean-Claude Somda	IRC	July 3 - Aug 14, 2011	To assist with production of BCC training manual and training of trainers	Ouagadougou / Kinshasa	40	Completed	

37	WASH Consultant	Munoz-Pierre Kenmeni	IRC	July	To conduct three trainings of trainers for building WASH structures (pit latrines, hand washing stations, rehabilitation of WASH structures, and bio-sand filters); produce training manual that includes plans and detailed instructions for the construction of the above	Cameroon/Kinshasa	40	Ongoing	Moved to Oct 26 - Nov 20, 2011
38	Newborn Health Activity Planning and Technical Assistance	Indira Narayanan	MSH	Jun 30-Jul 28, 2011	Train MNH advisor; strengthen planning on newborn health interventions	Arlington/Kinshasa	16	Completed	
39	PBF	Jean Kagubare	MSH	July 2-14, 2011	To provide technical support to develop the Performance Based Financing operational manual and conduct a training of trainers	Cambridge/ Kinshasa	14	Completed	
40	Project Management and Technical Assistance	Kristin Cooney	MSH	July 10-23, 2011	To provide technical support and guidance /reporting	Boston/Kinshasa	16	Completed	
41	Information Systems	Rabin Khadgi	MSH	Aug 15-Aug 26, 2011	Review IT systems and options for optimal IT Support to Kinshasa and other regions and orient the IT manager	Boston/Kinshasa	14	Completed	

42	Nutrition Activity Planning and Technical Assistance	Chouahibou Nchamoun	MSH	Aug 21-Sep 10, 2011	Train nutrition advisor; strengthen planning on nutrition interventions	Bamako/Kinshasa	16	Ongoing	Moved to Oct 3 - 31, 2011
43	BCC	Paul Neely	OSC	Aug 8-Sep 16, 2011	To develop, implement and monitor an SMS pilot in 16 IHP-targeted health zones (two HZ in each of the eight coordination office areas) to support community-based behavior change campaigns on family planning	Canada/Kinshasa	27	Completed	Moved to Aug 4 - Sep 10, 2011
44	BCC	Remi Vallet (replaces Charlotte Souibes)	OSC	Aug 8-Sep 16, 2011	To organize health sensitization workshops for journalists, host journalist site visits, work with the MOH to ensure regular health outreach events for the press, develop an earned media plan in each of the four provinces and set up procedures and systems for media monitoring.	Paris/Kinshasa	27	Ongoing	Moved to Sept 29 - Nov 1, 2011
45	BCC/Community Champion Consultant	Loulou Razaka	OSC	Sep 12 - Oct 21, 2011	To research and develop Community Champion (CC) approach, develop CC user manual, train field staff in	Madagascar/ Kinshasa	18	Ongoing	Moved to Oct 16 - Nov. 2

					the CC approach and use of the manual, and set up procedures and systems for media monitoring.				
46	BCC	Amelie Sow-Dia	Consultant	September 23-October 31, 2011	Review existing data; begin comprehensive baseline KAP assessment to guide BCC and other strategic communication components; work with Senior BCC Expert to develop BCC campaign materials; assist in launch of BCC activities; and initiate BCC training of local professional staff working in field offices.	Baltimore/Kinshasa	28	Ongoing	Moved to Oct 1 - 28
47	Operations and workplanning for Year II	Christele Joseph-Pressat	MSH	Sep 26-Oct 9, 2011	Work with finance/admin team on budgeting workplan produced during workplanning workshop	Boston/Kinshasa	16	Completed	
48	Operations, workplanning Year II, and technical support	Joan Marshall-Missiye	MSH	Sep 7-Oct 8, 2011	Provide technical support during workplanning workshop; visit project sites	Boston/Kinshasa	32	Completed	
49	Workplanning Year 2 and Technical Assistance	Jean Kagubare	MSH	Sep 19 -Oct 6, 2011	Provide technical support during workplanning workshop; visit project sites	Boston/Kinshasa	16	Completed	

					related to PBF				
50	Project Management and Technical Assistance; Workplanning Year 2	Kristin Cooney	MSH	Sep 21-Oct 7, 2011	Provide technical support during workplanning workshop; visit project sites	Boston/Kinshasa	16	Completed	
51	PBF	TBD	MSH	Sep 01-Sep 15, 2011	To conduct cost and revenue analysis	Cambridge/ Kinshasa	16	Postponed	
52	Workplanning Year 2	Karin Veltman	OSC	Sep 20-Oct 7, 2011	Provide technical support during workplanning workshop	Philadelphia/ Kinshasa	17	Completed	
53	Workplanning Year 2 and M&E Technical Assistance	Juan Carlos Alegre	MSH	Sep 25-Oct 7, 2011	Provide technical support during workplanning workshop; Training of M&E staff; visit project sites related to M&E system	Arlington/Kinshasa	16	Completed	
54	Commodity Security Technical Assistance	Tom Layloff	MSH	Sep 10-Sep 24, 2011	Provide technical assistance on quality assurance for essential medicines	Arlington/Kinshasa	12	Completed	
55	MNCH Activity Technical Assistance	Ciro Franco	MSH	Sep 4-Sep 24, 2011	Work with IHP and MOH on maternal health interventions; strengthening community care sites (CCM); providing input into annual workplanning	Arlington/Kinshasa	21	Ongoing	Moved to Oct 9 - 28, 2011

56	Commodity Security Technical Assistance	Ned Heltzer	MSH	Sep 10-Sep 24, 2011	Provide technical assistance on quality assurance for essential medicines, procurement, and distribution	Arlington/Kinshasa	12	Completed	
INTERNATIONAL TRAVEL IHP LOCAL STAFF AND PARTNERS									
Quarter 1 Oct-Dec 2010									
57	WHO Training	Narcisse Naia	MSH	March 1-March 4, 2011	Immunization Program Managers meeting for Central Africa	Kinshasa/Gabon	4	Completed	
58	WASH	Simeon Kenfack	IRC	01/04/2011	Travel to post for WASH Advisor	Ouagagougou/ Kinshasa	-	Completed	
59	HMIS	SNIS Representative	MOH	May 2 - 20, 2011	Travel to / from Measure Evaluation CESAG Seminar on Improving HMIS	Kinshasa/Dakar	18	Cancelled	
60	Regional Workshop on Pneumonia and Diarrhea	Gilbert Andrianandrasana	MSH	May 23-May 28, 2011	Attend WHO/UNICEF Regional Workshop on Pneumonia and Diarrhea	Kinshasa/Ouagadougou	6	Completed	
61	Public Health	DCOP	IRC	May 28-June 6, 2011	Travel to / from IRC Global Health Conference - DCOP	Kinshasa/Bangkok	10	Completed	Not charged to IHP
62	WASH	Simeon Kenfack	IRC	May 28-June 3, 2011	Travel to / from IRC Global Health Conference - WASH Advisor	Kinshasa/Bangkok	7	Cancelled	
63	USAID training	Finance Manager	MSH	June 20 -June 24, 2011	USAID/CDC Regulations & Policies -Financial Management of USAID/CDC Awards	South Africa (Pretoria)	6	Postponed	

64	USAID training	Contracts&Compliance Manager	MSH	June 20 -June 24, 2011	USAID/CDC Regulations & Policies -Financial Management of USAID/CDC Awards	South Africa (Pretoria)	6	Postponed	
65	USAID training	Finance and Administration Specialist	MSH	June 20 -June 24, 2011	USAID/CDC Regulations & Policies -Financial Management of USAID/CDC Awards	South Africa (Pretoria)	6	Postponed	
	Quarter 4 Jul-Sep 2011								
66	WASH	Simeon Kenfack's wife	IRC	July 11, 2011	Travel to post for WASH Advisor dependent	Ougadougou/ Kinshasa	-	Completed	
67	WASH	Simeon Kenfack's child	IRC	July 11, 2011	Travel to post for WASH Advisor dependent	Ougadougou/ Kinshasa	-	Completed	
68	WASH	Simeon Kenfack's child	IRC	July 11, 2011	Travel to post for WASH Advisor dependent	Ougadougou/ Kinshasa	-	Completed	
69	WASH	Simeon Kenfack's child	IRC	July 11, 2011	Travel to post for WASH Advisor dependent	Ougadougou/ Kinshasa	-	Completed	
70	Gender / GBV	Bridget Lombardo	IRC	July 22, 2011	Travel to post for Gender / GBV Advisor	Washington/ Kinshasa	-	Completed	
71	Gender / GBV	Bridget Lombardo's son	IRC	July 22, 2011	Travel to post for Gender/GBV Advisor dependent	Washington/ Kinshasa	-	Completed	
72	F&A	Lila Rabibisoa	MSH	Jul-11	R&R F&A Specialist	Paris/ Kinshasa return	15	Completed	
73	COP	Ousmane Faye	MSH	Jul-11	R&R COP	Senegal/Kinshasareturn	15	Completed	
74	USAID/East Africa FP Meeting	Pauline Kasuni	MSH	Jul 25-Jul 29, 2011	Attend USAID/East Africa FP meeting and serve as ongoing contact for	Nairobi / Kinshasa return	6	Completed	

					action plans developed at meeting				
75	WASH	Simeon Kenfack	Kinshasa/Douala Return	August 27, 2011	R&R WASH Advisor	Doula/Kinshasa return	14	Completed	
76	Gender / GBV	Bridget Lombardo	IRC	September 19-September 23, 2011	Travel to / from IRC Global Women's Protection and Empowerment Conference in New York - Gender / GBV Advisor	Kinshasa/New York return	5	Cancelled	
77	Gender / GBV	Bridget Lombardo's husband	IRC	September 15, 2011	Travel to post for Gender/GBV Advisor dependent	Washington/ Kinshasa	-	Completed	
78	Public Health	TBD	IRC	September 12-September 23, 2011	Travel to / from IRC Global Health Conference	Kinshasa / Bangkok	11	Cancelled	
79	Health specialist	Lara Ho	IRC	September 25 - November 3, 2011	Technical support to IHP activities including workplan workshop	Geneva/Kinshasa	40	Ongoing	
80	Partnership Compliance Coordinator	Jeanne Mundela	IRC	Oct. 2 - Oct. 11, 2011	Undergo official USAID training on rules and regulations	Kinshasa/Nairobi return	9	Completed	IHP covered 50% of travel expenses
		New trips requiring approval are indicated in olive green (these trips have been added or more precise details provided since the version of the STTA plan submitted on 08/04/2011)							