

## DRC-IHP Quarterly Report: April-June 2011

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Keywords: Integrated Health Project; maternal, newborn, and child health; water, sanitation, and hygiene; family planning/reproductive health; malaria, tuberculosis, and nutrition

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# Integrated Health Project

in the Democratic Republic of Congo



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DRC-IHP Quarterly Report: Year I, Quarter 3 (April-June 2011)

USAID Cooperative Agreement Number: AID-OAA-A-10-00054

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**Cover Photo:** In the Kamiji health zone in Kasai Oriental Province, on the second day of the national vaccination against polio campaign, a young boy prepares to receive the polio oral vaccine.

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## ACRONYMS

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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)
CAC	Cellule d'animation communautaire (community coordination unit)
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
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
HC	Health Center
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
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 (charge 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 élargi de vaccination (Expanded program of immunization—EPI)
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 health workers)
RH	Reproductive Health
RHC	Referral Health Center
RPR	Rapid Plasma Reagin Test for Syphilis
SNIS	National health information system
SPS	Strengthening Pharmaceutical Systems Project
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 third quarter reporting period of the first year of the five-year, USAID-funded Integrated Health Project (IHP) in the Democratic Republic of Congo (DRC), from April-June 2011. 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.).

The current reporting period from April to June 2011 saw the following key achievements:

- The utilization rate of health services in IHP's target areas has steadily increased and is now at 40%. This is comparison with the last two quarters, for which the rate was 29.3% and 32% respectively. Community residents may be seeking services at the health centers because they have qualified service providers, and the centers are equipped with drugs and medical supplies. In addition, increased data are available from the health zones.
- New acceptors of modern method family planning increased to 130,733 in this quarter, as compared to 100,213 in the previous quarter, and the number of counseling visits rose to 76,344 compared to 42,313 in the previous quarter. These increases may be due to the availability of products in the health centers and to the motivation of the community-based distribution agents who are starting to receive bicycles to help them conduct their work. IHP provided an initial lot of 125 bicycles to 60 agents in the coordination area of Mwene Ditu and 65 in coordination area of Luiza in June. The agents increased not only the number of their counseling visits, but also the number of villages and health areas visited.
- The number of prenatal counseling visits recorded in the health education activities supported by IHP increased to 120,201 in the quarter, compared to 89,017 in the previous quarter.
- The number of women benefiting from Active Management of Third Stage Labor rose from 51,156 in the second quarter to 76,852 in this reporting period.
- The number of insecticide-treated mosquito nets distributed to pregnant women and children under five in the period was 188,412, compared to 72,089 in the previous quarter. This increase was essentially due to the availability of the product in all health facilities.
- Children who had malaria and were treated properly, according to protocol, increased significantly, up to 222,433 in this quarter as compared to 140,085 in the previous quarter. Most of the health providers are now trained on the new national protocol including the use of rapid diagnosis tests before treatment, and these tests are now available in the health centers. Additional data are also available as compared to the previous reporting period.
- The number of pregnant women who benefited from HIV counseling, agreed to be tested, and received their results rose from 9,598 in the second quarter to 18,720 in this reporting period. This improvement is due to increased competency of health providers, availability of drugs and lab reagents, and clients receiving test results the same day. Additional data are also available as compared to the previous reporting period.
- IHP provided support for the polio vaccination campaign, measles campaign, and vitamin A supplement campaigns. This included technical support (coordination and supervision), logistical assistance (transportation of vaccines), and monitoring support in Bukavu, Uvira, Kasai Occidental, Kasai Oriental, and Katanga. The number of children vaccinated was as follows: Sud Kivu: 1,615,060; Kasai Occidental: 50,934; Kasai Oriental: 172,156; and Katanga: 124,459.
- In June, IHP organized an official presentation of the project for authorities in the provinces of Katanga, Sud Kivu, Kasai Oriental, and Kasai Occidental. These presentations focused on the mission, vision, objectives, different areas of intervention, and the main activities of the project.

These events provided the opportunity for IHP to establish direct contact with the local authorities, who also took this occasion to explain the real needs and current health situation in their areas. IHP staff explained how IHP could respond to the expectations of the Provincial Ministry of Health and the local political-administrative authorities.

- IHP has just completed a baseline survey in the health zones supported by the eight IHP coordination offices. The survey was conducted in nine supervision areas, each one corresponding to the supervision area for each coordination office except for the Bukavu office, for which there are two. The general aim of the survey is to establish a benchmark that will enable IHP to reliably assess the interventions that will be made in the course of its implementation, to help measure the progress of performance in the supported health zones and provinces. The draft report of this study has been presented to USAID for comment.
- In the four project-supported provinces, LDP training of members of the provincial management teams of the political and administrative authorities was effective. A total of 375 persons were trained and assisted, and acquired knowledge about leadership. The LDP training was combined with fully functional service delivery point training (FOSACOF). The LDP will help provincial and health zone authorities and teams concentrate on obtaining real results, developing leadership and management capacity *at all levels*, getting them to assume responsibility for the process, and ensuring sustainability of the impact by implementing new processes and obtaining measurable results.
- IHP provincial representation offices are open in three provinces, to resolve problems of visibility and representation, and to provide technical assistance to the provincial health divisions and health ministries. Two former directors of Luiza, Mwene Ditu, and Bukavu have been appointed as representatives of Kasai Occidental, Kasai Oriental, and Sud Kivu, respectively, and one of the field office supervisors has assumed the duties of provincial representative in Katanga.
- From May 15 to 19, a USAID team visited the Kolwezi coordination office. The purpose of the visit was to review the activities of the IHP coordination office, visit the pharmaceutical warehouse (CEDIMEK), and visit the health zones of Fungurume, Lubudi, Lualaba and Manika. The trip provided an opportunity for USAID to identify some of the challenges associated with IHP start up in Kolwezi and to propose some recommendations and immediate actions to ensure that gains made by the previous AXxes Project are maintained and that IHP is able to achieve its expected results in this region.
- Three regional distribution centers (CADIMEK, CADMEKO and FODESA) each signed a new contract with IHP for the management and distribution of the essential drugs and medical supplies they have in their stores. As of June 30 IHP also signed contracts with CDMEK Kolwezi, CEDIMEK Kamina, and the three distribution centers in Bukavu (BDOM, APAMESK and 8è CEPK).
- WASH activities were launched with the recruitment of the WASH advisors, the distribution of WASH equipment to all eight coordination offices, and the identification of the villages which will participate in the Clean Villages program in Kamina, Bukavu, Kolwezi, and Uvira. The remaining coordination offices planned their WASH activities for the next quarter (Luiza, Mwene Ditu, Kole and Tshumbe).

- HP finalized most of its recruitment for all coordination offices, including Uvira, Bukavu, and Kolwezi, which were delayed in recruitment during the last quarter.

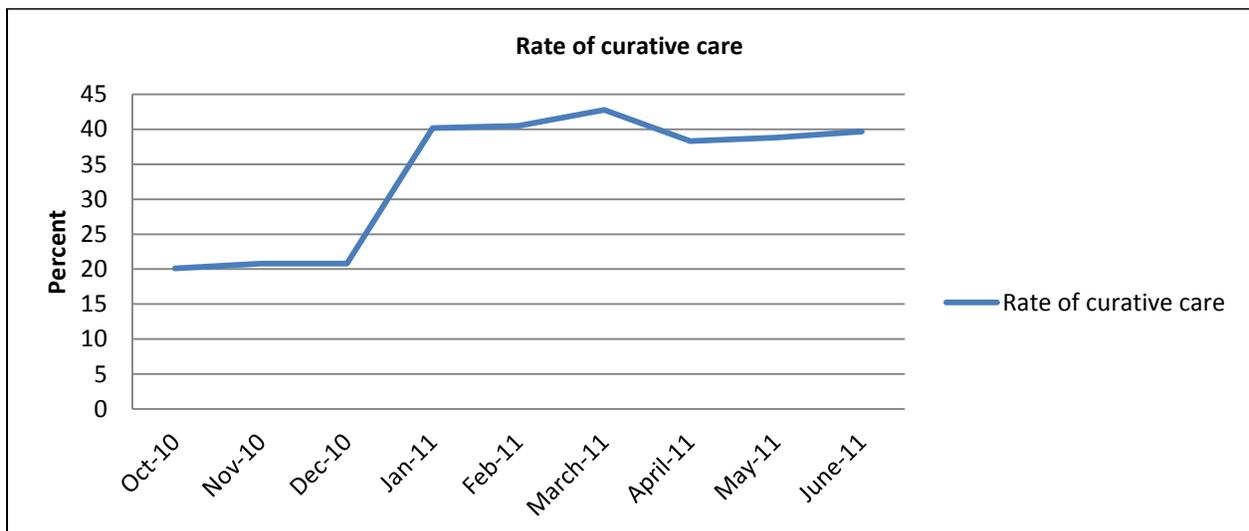
## I. PROJECT PERFORMANCE: ACTIVITIES AND ACHIEVEMENTS

### I.1 COMPONENT 1: HEALTH SERVICES

#### I.1A (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

The service utilization rate is steadily increasing in comparison with the last two quarters, for which the rate was 29.3% and 32% respectively. The rate is now at 40%, as illustrated in Figure 1, below. Community residents are seeking services at the health centers because they have qualified service providers, and are equipped with drugs and medical supplies.

**Figure 1: Utilization rate of health services in IHP target areas: October 2010-June 2011**



From April to June, IHP staff provided technical and financial support to health zone management teams who carried out 85% of planned supervision visits in the health zones supported by the eight coordination offices. Some zones were not visited, such as Mulungu in Sud Kivu, due to lack of security in the region. During these visits, the main challenges inherent in improving PMA and PCA-plus service quality and effective coverage in health care areas were identified as follows:

- Weak vaccine coverage due to stock-outs of certain antigens and of SBSs.<sup>1</sup>
- Weak application of the strategy put forward.
- Inactivity on the part of some community health workers.

To address these problems, IHP strengthened its support for the affected health zones, by providing:

<sup>11</sup> SBS: Self-blocking syringes used for injecting vaccines. They are adapted to the doses and antigens, and are for one-time use.

- Support for campaigns against measles in 26 health zones and against poliomyelitis in 79 health zones (with the exception of Mulungu, due to the security situation).
- Transportation of vaccines, and assistance with close independent monitoring.
- Support for community-based monthly monitoring in the health areas.
- Monthly review of activities in the health zone central offices (BCZ) with the zone management teams (ECZ).
- Conducting quarterly reviews in certain health districts, such as Kamina, Mwene Ditu, and Kole.
- Organization of follow-up visits on the performances of the health zones.

In Sud Kivu and Katanga, IHP collected baseline information on the conditions of the health zones and established an inventory of their equipment, specifically in Bukavu, Uvira, and Kolwezi, with the exception of Mulungu health zone which remained inaccessible due to insecurity in the area. The situation is improving and it is expected that the baseline in Mulungu will be carried out in the next reporting period.

Certain items of equipment from the AXxes project that were not included on the AXxes inventory provided to the field offices were found during field visits. An updated inventory of AXxes equipment can be found in Annexes 9, 10, and 11.

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

#### ***Activity 2: Prioritize and implement infrastructure improvements to target health zone facilities***

The IHP teams in the two Sud Kivu offices, in collaboration with the ECZ, selected health facilities to be renovated in the current project year. A total of 10 centers were selected in Bukavu, two each in the health zones of Kadutu, Ibanda, Bagira, Miti Murhesa, and Nyangezi. A further five centers were selected in three health zones under the Uvira coordination area – Nundu, Ruzizi, and Uvira. In order to expedite the launch of renovation to make up for project delays to date, the health zones with the easiest access, situated the closest to IHP coordination offices, were selected. These facilities were selected based on their proximity to IHP coordination offices, with the input of the head zonal doctors (médecins chefs de zone).

An IHP construction consultant conducted a detailed survey of the work required based on visits to all facilities with a project team and the local CODESA. The consultant subsequently drew up rehabilitation plans for each structure, and the work which will be carried out will be supervised by IRC Bukavu's construction coordinator. The process of selecting a construction company was launched through a competitive process. The final selection will be made early in the next reporting period in order for work to begin in July 2011.

In addition, IHP rehabilitated two latrines for Bagira General Reference Hospital in Bagira health zone and in Kavumu hospital in Miti Murhesa health zone.

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

Three regional distribution centers (CADIMEK, CADMEKO and FODESA) each signed a new contract with IHP for the management and distribution of their current stock of essential drugs and medical supplies.

As of June 30 IHP also signed contracts with CDMEK Kolwezi, CEDIMEK Kamina, and the three distribution centers in Bukavu (BDOM, APAMESK and 8è CEPAK).

In Sud Kivu, medicines remaining from the AXxes project valued at \$161,049 are in stock in the BDOM warehouse, which supplies all of Sud Kivu. However, stores of many key medicines, such as quinine and several types of antibiotics, are depleted. IHP is currently awaiting the next delivery of medicines in the coming trimester to replenish these supplies. IHP staff began distributing the available stock to those health zones that are experiencing stock outs, while the remaining health zones' supplies will be replenished upon arrival of the next shipment.

In Kolwezi, medicines to a total value of \$42,925 are in stock in the warehouse; however stores of many key medicines such as several types of antibiotic, quinine, folic acid, surgical gloves, suturing equipment and anesthetics are depleted. As mentioned above, stocks will be replenished in the coming quarter.

IHP delivered Presidential Malaria Initiative (PMI) products to health zones, in particular Artemisinin Combination Therapy (ACT), rapid diagnosis tests, and insecticide-treated mosquito nets intended for pregnant women. Exact distribution figures of nets by health zone can be found in Annex 4. In accordance with the distribution plan aligned with the national plan, the Regional Medicine Distribution Center distributed 201,600 doses of ACT in 13 health zones in Sud Kivu. In addition, a small quantity of HIV tests was available (1,000 "Determine," 200 "Unigold," and 200 "double check"), and IHP distributed these to eight Prevention of Mother to Child HIV Transmission (PMTCT) sites in Bukavu city. The remaining 60 sites will receive these tests as soon as more are available. Five health zones in Bukavu and four in Uvira received family planning items, including Depo Provera, condoms, and contraceptive pills. IHP teams continued to sensitize the remaining health zones that had not placed orders on the necessary procedures to ensure deliveries of these drugs. Insecurity in Mulungu and Kalehe health zones in Sud Kivu prevented distribution to these zones and, with the current improvement in the security situation, it is expected that distribution will be possible during the next reporting period.

In Kolwezi, Fungurume, and Manika health zones the IHP team distributed a total of 57,225 rapid diagnostic tests (RDTs) in the targeted zones. In addition, IHP distributed ACT tests to all eight health zones in Kolwezi, as detailed in the table below.

**Table 1: ACT distributed to Kolwezi health zones**

Age group	Planned quarterly quantity	Quantity distributed to health zones	Quantity in stock at the district level	Months of stock available
0-11 months	3275	3775	1350	1.2
1-5 years	52407	48875	23075	1.3
6-13 years	40943	38825	51475	3.8
> 14 years	45038	43000	102725	6.8

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

IHP signed contracts with the three warehouses selected by SPS/MSH in Sud Kivu and one warehouse each in Kolwezi and Kamina. The warehouses are responsible for the storage and distribution of IHP medical supplies (medicines, mosquito nets, and family planning items). The warehouses will be

managed by their owners, under the close supervision of IHP and SPS teams to ensure safe storage of all items. Health zones are responsible for requesting medicines to be delivered to them, using the credit lines that IHP makes available to them, and this process is governed by an agreement signed between IHP/SPS and the warehouse owners.

**Activity 5: Improve the capacities of human resources to deliver MPA and CPA-plus packages**

IHP supported a five-day workshop in collaboration with the 5<sup>th</sup> Direction of the Ministry of Health for Training of Trainers at the national level to introduce the updates to the clinical flowcharts. IHP provided financial and logistical support, provided 19 trainers, and provided technical input to the update of the clinical flowcharts.

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

**Activity 1: Integrate CODESAs into health zone strengthening activities**

During the quarter, the IHP team continued to provide support to revitalize community participation. IHP recruited six BCC Specialists in the offices of Kole, Kolwezi, Mwene Ditu, Bukavu, Kamina, and Tshumbe, and will complete recruitment in the two additional offices early in the next quarter. In addition, IHP recruited 10 Community Mobilization Specialists for all eight coordination offices (Bukavu has three community mobilization specialists while the other offices have one each).

The community mobilizers helped the health zone community facilitators to produce a status report, and an inventory was made of the existence of health development committees and their functionality. The situation of the 31 health zones in regard to community participation is known, and the BCC team has evaluated CODESA functionality using the criteria it developed by referring to the manual of procedures for the operation of the existing CODESAs (keeping and sending out minutes of meetings of CODESA members, attendance list). This exercise has made it possible to identify functional and non-functional CODESAs in IHP’s zones of intervention, in the coordination offices of Luiza, Mwene Ditu and Kole. The following table illustrates the operational status of the CODESAs:

**Table 2: Operational status of CODESAs in select IHP coordination areas**

Coordination Office	Number of CODESAs	Number of Functional CODESAs	Number of Non-Functional CODESAs
Luiza	175	71	104
Mwene Ditu	194	106	88
Kole	55	36	19

In Mwene Ditu, 14 community facilitators and 11 supervising nurses from the 11 health zones served by the coordination office took part in a training offered June 4-8, 2011, to become trainers in community participation and communication techniques. The training focused primarily on communication techniques and the development of communication materials for behavior change. It was coordinated and organized in direct collaboration with the 10th directorate of the Ministry of Health.

These trainers will develop their own action plans, prepare a status report on the functionality and operationalization of the CODESAs in the health areas, and then plan on-site supervision. They will also put in place community participation bodies and community facilitation cells.

In Luiza, the coordination team produced a status report at the end of May on the functionality of the CODESAs in their area. The report findings include:

- At least one community participation body exists in a health area.
- The population is very interested in community activities.
- Every community has an action plan relating to community development.
- CODESA members suffer from lack of motivation because supervision is inadequate and they receive no compensation.
- Some village chiefs are not involved in creating CODESAs.
- Some head zonal doctors (*médecins chefs de zone*) show a lack of interest in community activities.

Following this status report, Luiza's BCC Specialist held sessions to revitalize the CODESAs (focusing on supervision, roles and responsibilities, introduction to development activities, etc.). These sessions covered:

- 14 of 16 health areas in Dibaya
- 4 of 12 health areas in Tshikaji
- 4 of 14 health areas in Bilomba
- 2 of 18 health areas in Luiza.

A field visit is planned for the next quarter, in order to revitalize the remaining structures.

In Bukavu, Uvira and Kolwezi IHP teams conducted an evaluation on the presence and functionality of CODESAs, which determined that the majority of CODESAs are not functioning, particularly those in Kolwezi's health zones, and that most CODESAs are coming to the end of their mandate and require reelection. In the coming trimester, IHP will conduct training sessions and support elections. Training will focus on the role of the CODESA and the community in health zone activities. CODESAs that are still operational (70% in Bukavu) will participate in the monitoring of any rehabilitation work undertaken in the coming quarter and will oversee the handover of these structures once the work is completed.

***Activity 3: Scale up community case management and treatment of childhood illnesses (e.g., malaria, diarrhea, and pneumonia)***

**Review of documentation on IMCI-C:** IHP collaborated with the Ministry of Health and its other partners in providing feedback on the documentation concerning the integrated management of childhood illnesses in community case management sites. This activity involved determining the best practices for dealing with bottlenecks, then defining and developing the next steps in scaling up the treatment sites.

**Attendance at key regional workshops:** During this quarter, the Senior Technical Advisor and Technical Advisor for PCIME traveled to Senegal to participate in two regional workshops organized by the WHO in collaboration with USAID, UNICEF, and the Bill & Melinda Gates Foundation, to gain state-of-the-art knowledge to contribute to the IHP mandate on integrated management of childhood illnesses and integrated maternal, newborn and child health as well as to serve as members of the well-represented

DRC delegation, which was composed of representatives of the MOH Family Health Directorate, the director of the national program against diarrhea, the director of national program against pneumonia (PNLIRA), and representatives of WHO/DRC.

With a primary theme of “Protect, Prevent, and Treat” using a coordinated approach for the prevention and control of pneumonia and diarrhea, the 4-day Regional Workshop on Pneumonia and Diarrhea, focused on the following specific objectives:

- **Become familiar** with the concepts and the principles of the worldwide action plan to prevent and to fight pneumonia (GAPP) and strategy to control diarrhea including the relationship with other health programs and the impact for the health systems.
- **Analyze opportunities** and barriers to the implementation, share lessons learned, and identify appropriate solutions to improve the impact of the interventions in term of coverage on preventing and controlling pneumonia and diarrhea inside the child survival strategies.
- **Stimulate the collaboration** and the link between programs on identifying and developing specific coordinated actions for the implementation of GAPP practices and strategies regarding diarrhea and pneumonia.
- **Establish sufficient and appropriate resources and technical assistance** to implement a coordinated action plan in each country.
- **Enhance awareness** in terms of advocacy at the country level, in order to speed up action plan implementation against pneumonia and diarrhea.

Participants from Benin, Burkina Faso, Chad, DRC, Mali, Niger, and Senegal attended sessions that included: (1) country presentations; (2) advocacy and communication; (3) monitoring systems and data collection; (4) country action plans; and (5) financing opportunities. The DRC team developed an action plan that included organizing a workshop to review an integrated plan of communication to include all stakeholders; developing an advocacy document and plan for the provincial governors to mobilize local resources for child survival; developing and implementing a community case management sites extension plan; reviewing and developing as needed IEC materials for community health workers; and reviewing and using appropriate data collection tools to ensure high-quality data.

The second workshop in Senegal, the Regional Workshop on Integrated Community Health (Maternal, Neonatal and Children’s Health and Nutrition), was held from June 20 to 23, 2011: This workshop was held to promote implementation and scaling up of an integrated package of interventions in the area of maternal, neonatal and children’s health and nutrition, at the community level, through a continuum of preventive, promotional and curative care and sharing, by the participating countries, of their experiences in terms of good practices and lessons learned.

**Revision of PCIME tools and directives:** To improve the services provided by health care agents who work with children in health centers and in the community, and who have incorporated the PCIME strategy in the DRC, IHP supported a workshop held in Kisantu from June 6 to 11, which was dedicated to revising and updating certain tools and directives concerning clinical and community PCIME and the pharmaceutical sectors. Twenty-four experts from the Ministry of Health and from partners working in the PCIME field participated in the workshop.

Also during the quarter, IHP hired an international maternal and child health consultant. The specific objectives of the consultation were:

- Provide technical assistance to IHP technical team on the packages of interventions for family planning, post-abortion care, and maternal, newborn and child health as well as share updates, innovative approaches and methodologies in this area.
- Review the national protocol regarding the AMTSL methodology and evaluate the training module developed by the AXxes project in collaboration with the ICCM national program, reproductive health national program and MCHIP (Maternal and child health integrated program) and used by USAID implementing partners to train health facilities providers.
- Provide recommendations and feedback to IHP and the MOH on areas needing improvement.

The consultant recommended a rapid health facility assessment be made to identify and then focus on weak areas that need to be strengthened. This assessment would involve a small sample of health facilities in some representative health zones, and include observation of IMCI care, exit interviews with mothers, and provider interviews. The consultant also looked at IHP's efforts to scale up AMTSL, in particular the concerns about the use of oxytocin because of the potential malfunction of the cold chain. The use of Misoprostol at facility level would remove this concern, and it is easier to administer, as it is oral rather than injectable.

The consultant also suggested that IHP expand the scope of CCM sites in the 49 health zones, using a team approach in which the entire MNCH/FP package will be rolled out. The team will be comprised of the Relais de Site (RS) and Relais Promotional (RP). The RS will continue to be the provider for treatment of malaria, diarrhea and ARI, while the RP will be engaged in promoting maternal, newborn and child health in the community. The consultant also discussed with IHP the opportunity to integrate family planning (FP) services into different health services such as EPI, GMP, ANC, delivery/postpartum. The consultant suggested using the "collaborative" approach to improve care provided at community level as well as the referral and support linkages between the community health workers (CHWs), the community and the health center.

The timeline for the next steps based on the consultant's findings is as follows:

1. July/August: Assessment of the CCM sites, with findings available in September
2. September/October: IMCI assessment
3. September: Using Lives Saved Tool (LIST)
4. September: Launch of Collaborative approach

A national consultant is being hired to carry out and produce a status report on the existing community health care sites in 49 health zones. This activity is to start in the last week of July and will run for two months. The objectives of the consultation is to provide IHP with up-to-date information on the 477 community health care sites in 49 supported health zones, to support decision-making and reinforcement of activities.

**Evaluation of community case management of childhood illnesses:** IHP teams in Sud Kivu and Kolwezi carried out an evaluation of community case management of childhood illnesses in collaboration with the Provincial Health Division. Of the community treatment sites identified, in Uvira, approximately 40% are currently functional, as are approximately 42% of those in Kolwezi and 40% of those in Bukavu. These low levels of community case management can be explained by several reasons, including the disengagement of the Health Zone Management Teams and the ECP (in Lamera and Uvira), insecurity (in Hauts Plateaux, Ruzizi, Nundu), lack of medicines and information tools, or that the community agents were involved in other activities (Kolwezi, where many were working in the mining sector).

Based on the assessment of site functionality, IHP will formulate a plan to reactivate community treatment sites in all target project sites in Sud Kivu. This plan will include post-training monitoring of 348 community agents in 87 sites who were previously trained by the provincial health division with support from the AXxes project on community case management and treatment of childhood illnesses. The monitoring will involve a review of their current knowledge and practices; a review of the tools used at treatment sites; observations of how community agents act when a medical case arises, with corrections and advice provided when necessary; distribution of site management tools (such as medical registers, pre-school medical check cards, timesheets, etc.); and the provision of medicines from health centers linked with the community treatment sites.

IHP teams also began work on the distribution strategy for medicines to community treatment sites, taking into account the reluctance of health centers to hand over medicines to community sites due to differences in tariffs between the health center and the community sites. Because the medicines and care available at community sites are considerably more limited than at the health centers, the tariff to access these services is lower at the community sites and therefore, a certain competition exists between the two health services.

Finally, IHP delivered storage cupboards left over from the previous AXxes project to community treatment sites in anticipation of the delivery of medicines.

***Activity 4: Scale up evidence-based community WASH pilots***

The IHP WASH advisor visited IHP teams in Bukavu, Uvira and Kolwezi in order to finalize the recruitment and orientation of WASH staff in each office and finalize activity planning in order to meet targets for water points and hand washing facilities; and to construct latrines in the coming trimester. The 10 recruited WASH specialists started their assignments; three (3) of them are based in Bukavu.

IHP has requested that health zone community mobilization teams, supervised by the WASH office of the Provincial Health Division, carry out the WASH evaluation. In the current reporting period, the teams completed the evaluation in villages in half of all target health zones and IHP staff began data entry of the results for analysis. The evaluation results for those available can be found in Annex 7.

IHP identified villages suitable to participate in the Clean Villages initiative: 60 villages were identified by the Bukavu office, two in Uvira and 20 in Kolwezi. A table detailing those villages selected can be found in Annex 14. Additional villages will be identified early in the next reporting period in the coordination areas of Kamina, Mwene Ditu, Luiza, and Sankuru.

The IHP WASH strategy had been shared with the WASH national actors of the MOH, UNICEF and members of the WASH Cluster groups in Kinshasa, Sud Kivu and Katanga provinces. A WASH consultant has been recruited to conduct a series of three TOT sessions on the Community-led Total Sanitation (CLTS) and participatory hygiene and sanitation transformation (PHAST) approaches for WASH in Bukavu (for the Sud Kivu), Lubumbashi (for the Katanga IHP offices) and Kananga for the 4 IHP offices in the West and East Kasai provinces).

IHP developed a global workplan of WASH activities for the remaining three months of year 1 of the project – including detailed and budgeted implementation workplans at the local level for each of the eight IHP coordination offices –and discussed these plans with all of the WASH specialists.

As part of the implementation of these eight detailed plans, the following activities have been developed:

1. In Kinshasa, a first batch of 1,000 drinking water buckets (*poste d'eau potable, or PEP*), which can optionally be used as hand washing devices, have been purchased and are ready to be sent to the health zones of Kamina (260), Kole (140), Luiza (235), Mwene Ditu (240) and Tshumbe (125). At the same time, the IHP WASH specialists in Bukavu, Uvira, Kolwezi and Kamina have been trained to locally produce the PEP in their respective area.
2. The rehabilitation of two blocks of 6 cubicles (at the General Referral Hospital of Bagira) and 8 cubicles (at the maternity of the GRH of Miti Murhesa) in the Sud Kivu has been completed.
3. In the IHP coordination office of Bukavu, Uvira, Kolwezi and Kamina, the work sites for water, sanitation and hygiene infrastructures in the project supported health centers and communities have been identified, and the technical studies for the implementation of these activities are underway. The purchase of necessary materials is also underway (except for local materials which the communities and CODESAs have agreed to provide).

The WASH baseline data sheets – collected by the community health workers, centralized at the IHP field offices and submitted to the IHP headquarters in Kinshasa – are currently being verified and will be analyzed during the next quarter to produce a WASH baseline report for the 80 health zones.

To coordinate WASH activities and increase involvement in activities, IHP WASH staff met with the national “Village Assaini” program representatives in Kinshasa (national level) and Bukavu, Lubumbashi, Kananga and Mbudji Mayi (provincial levels) and other important WASH actors including UNICEF, CPAEA and SNHR representatives in Bukavu (Sud Kivu) and Lubumbashi (Katanga).

### **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.***

In the current reporting period, IHP focused on reinforcing the capacities of staff of the Principal Provincial Inspection and the 27 target health zones in Sud Kivu through the Leadership Development Program (LDP). This activity was carried out in three phases:

1. **April 14-19, training of trainers:** IHP trained a total of 20 members of staff of the Sud Kivu Provincial Health Inspection on the Leadership Development Program.
2. **April 20, senior alignment meeting:** IHP organized a senior alignment meeting, attended by 20 participants including local government representatives, provincial deputies, doctors and nurses, with the goal of ensuring that the local authorities took ownership of the LDP.
3. **April & June, health zone workshops:** IHP organized workshops for health zones in Sud Kivu with the participation of five members of each health zone management team. These workshops aimed to familiarize participants with the challenges encountered in working in the health center, and how to identify their causes and overcome them, in order to produce improved project results. Workshops were held:
  - April 22-25, with representatives participating from 11 health zones in Bukavu (Ibanda, Bagira, Kadutu, Walungu, Mubambano, Kaniola, Nyangezi, Mwana, Kaziba, Katana, Miti Murhesa).

- June 8-10, 2011, with two LDP workshops covering Sud Kivu's target health zones offered simultaneously, with a total of 22 participants from health zone management teams.
- June 9-11, 2011, an LDP workshop was held with the participation of members from five health zones under the Uvira coordination office.

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

IHP provided financial support to organize the first meeting of the Comité Provincial de Pilotage, June 1 and 2 in Bukavu, presided over by the Provincial Health Minister. The meeting's objective was to adopt the provincial operational action plan and drive the application of health policy at the provincial level.

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

Contractual issues continued to delay the signature of agreements with health zones and prevented IHP from providing funds and support to provincial and district level authorities to assist health zones. Despite this, IHP technical coordination teams accompanied the district office representatives on field visits, made inventories of equipment available, and actively collected health information that was not previously available.

**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**

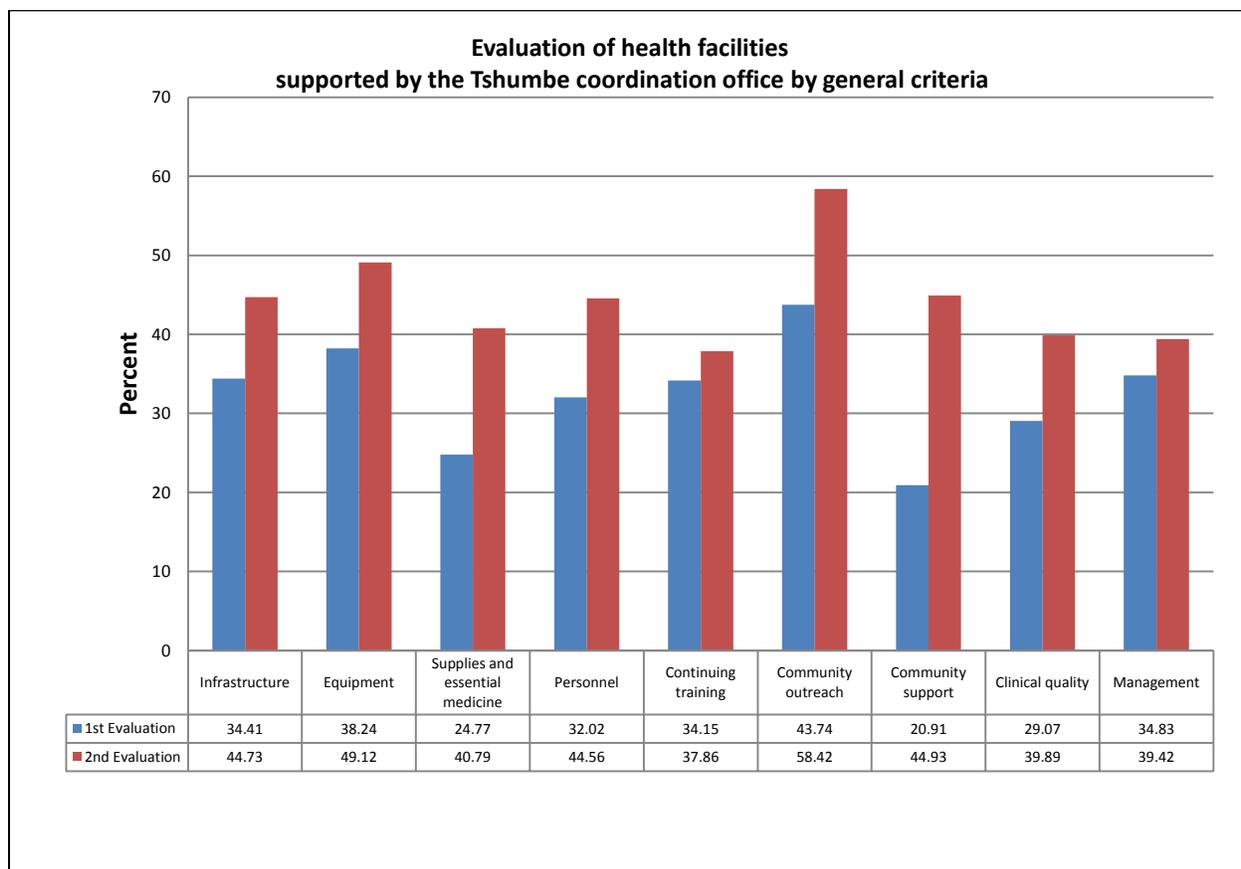
***Activity 1: Reinforce competency-based training for specific identified skills***

Twenty-eight service providers (three women and 25 men) from 11 health zones received FOSACOF training in the Mwene Ditu IHP coordination office, in order to improve the technical quality of the services offered, as well as IHP interventions in the fields of infrastructure, supplies and essential drugs, human resources, training, community outreach and support, and health training management.

In June, FOSACOF methodology was applied to carry out a qualitative evaluation of the health care structures in the coordination offices of Luiza, Mwene Ditu and Tshumbe, and to develop a revitalization plan to improve service quality.

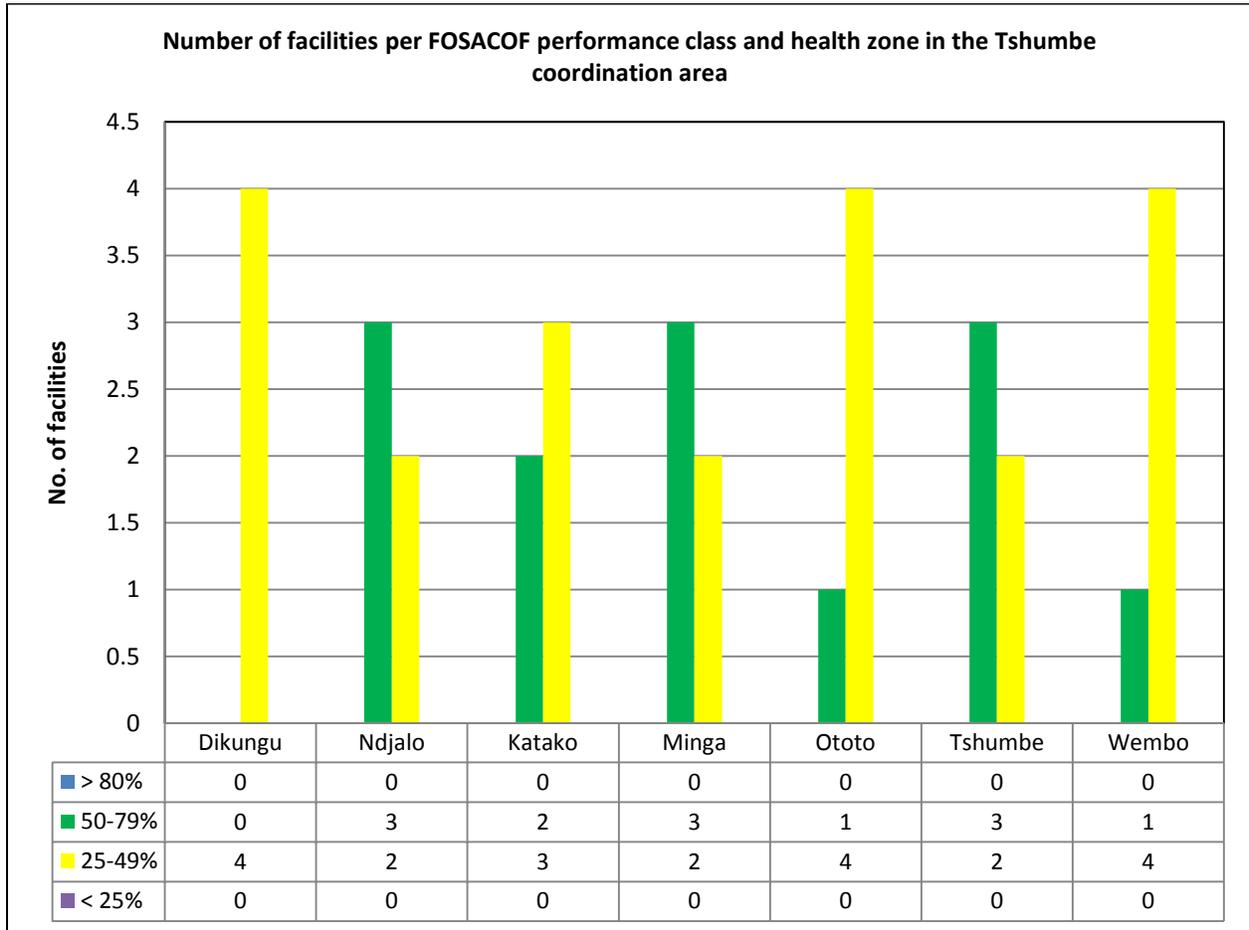
A summary of the results obtained according to the nine evaluation criteria is attached in Annex 6.

**Figure 2: Evaluation of health facilities supported by the Tshumbe coordination office by general criteria**



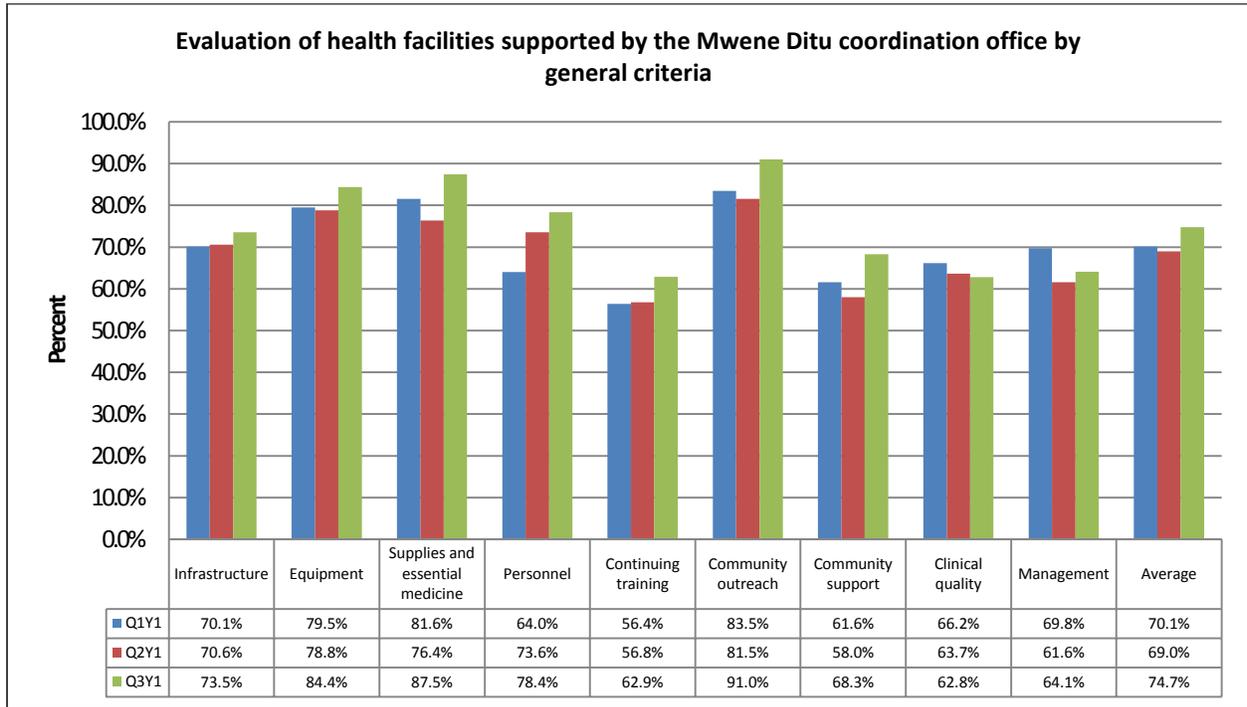
**Comments:** In comparing the two evaluations, we noted an improvement for all the general criteria, with more effort concerning the community support and community outreach criteria as a result of the work done by the community mobilization specialist. Nevertheless, no criterion exceeded 60% for the average of the coordination offices.

**Figure 3: Number of facilities per FOSACOF performance class and health zone in the Tshumbe coordination area**



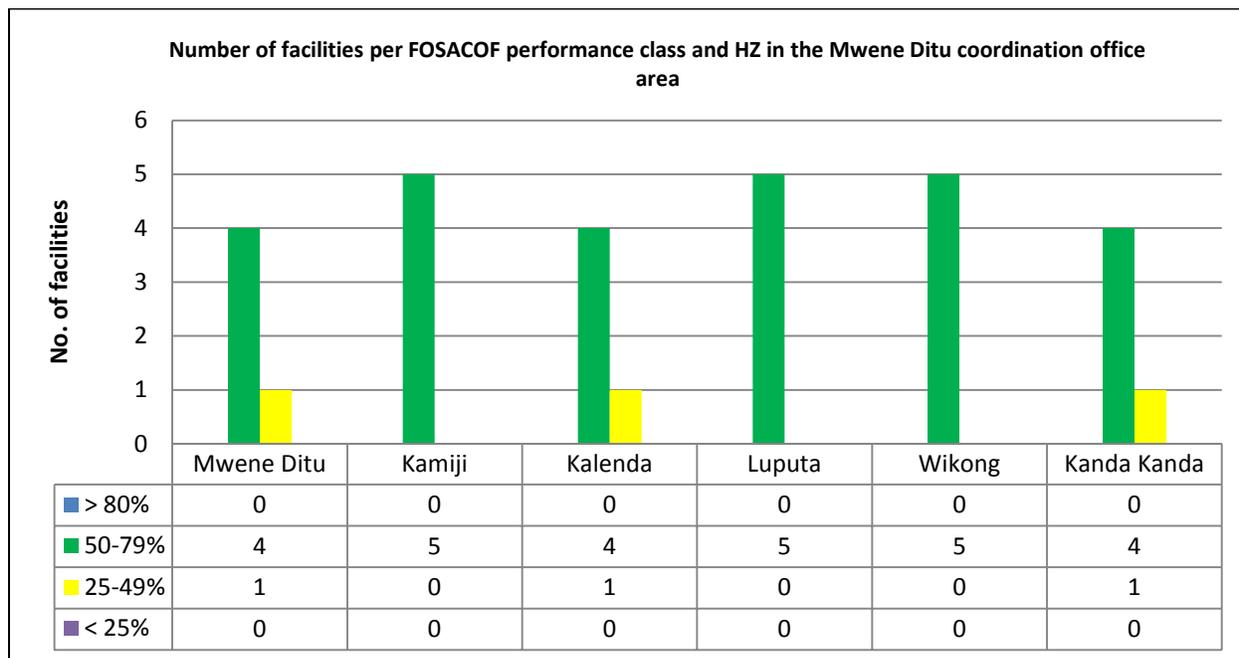
**Comments:** In the Tshumbe coordination area, most of the structures, namely 21 out of 34 or 62%, are in the non-functioning FOSACOF class, while 13 structures (38%) are in the average functionality class.

**Figure 4: Evaluation of health facilities supported by the Mwene Ditu coordination office by general criteria**



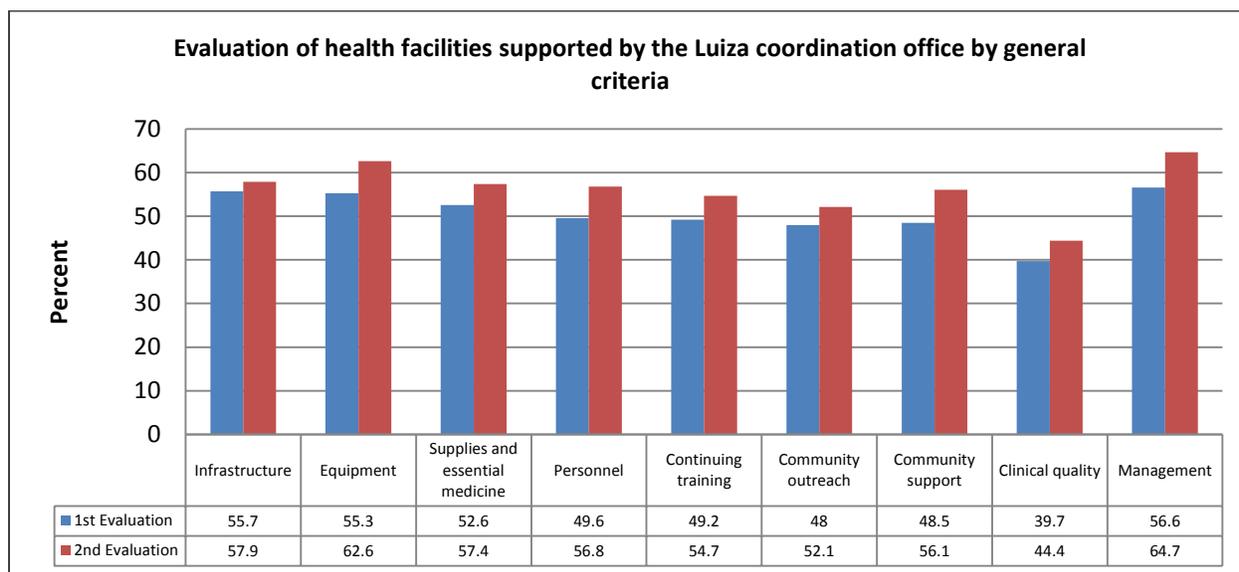
**Comments:** In the Mwene Ditu coordination office area, three FOSACOF evaluations have been conducted since the start of IHP, and the latest evaluation shows continued improvement. Last quarter scores averaged 69% compared to scores this quarter, which were at 74.7%. The community outreach criterion exceeded 91% for the average of the facilities covered by this coordination office.

**Figure 5: Number of facilities per FOSACOF performance class and health zone in the Mwene Ditu coordination office area**



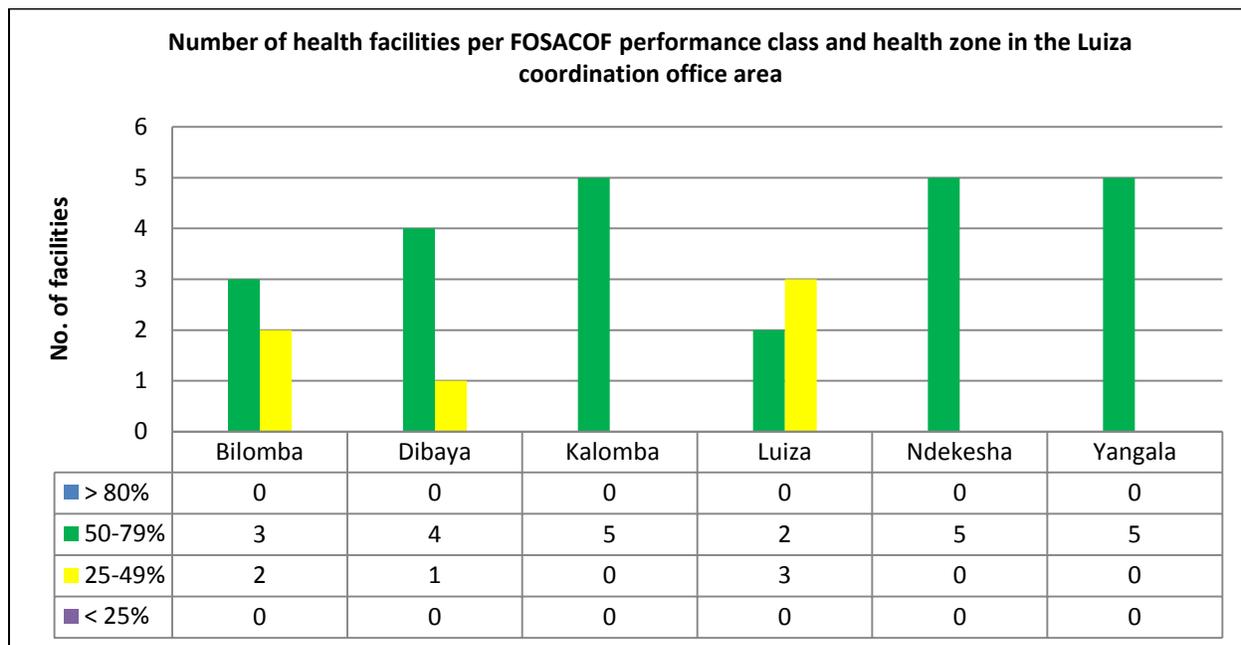
**Comments:** 90% of the FOSACOF structures demonstrate average functionality, while 10 are non-functional.

**Figure 6: Evaluation of health facilities supported by the Luiza coordination office by general criteria**



**Comments:** As in the case of the first two coordination offices, scores continue to increase. Here it is the management criterion that has the best score among the structures in general.

**Figure 7: Number of health facilities per FOSACOF performance class and health zone in the Luiza coordination office area**

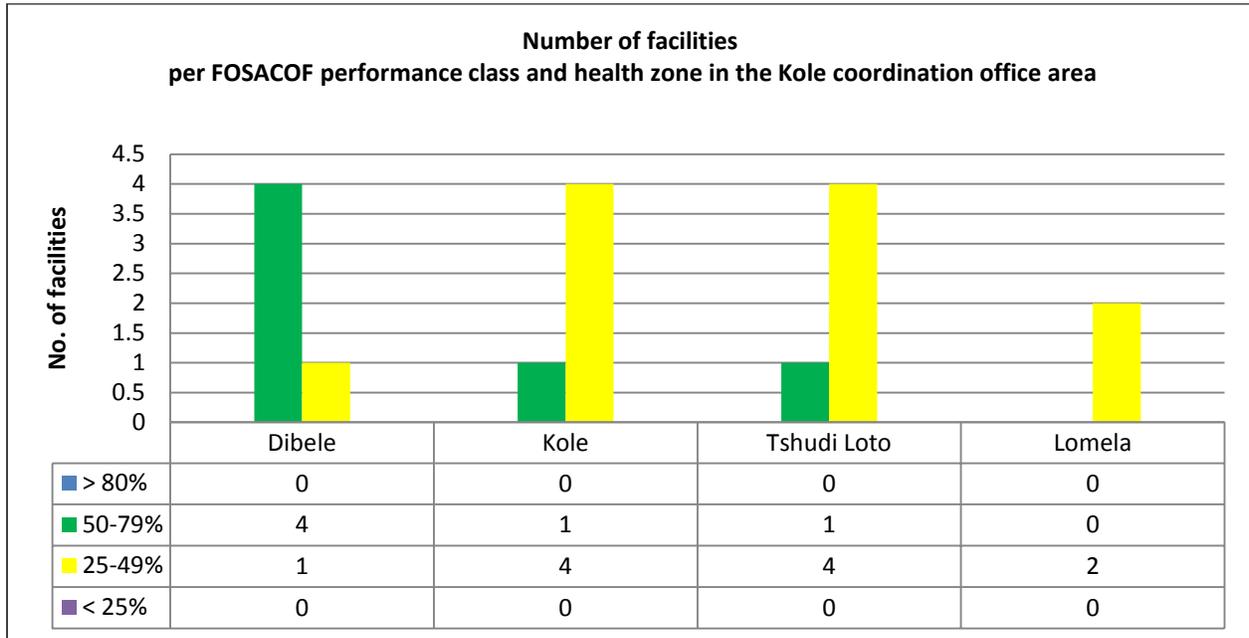


**Comments:** Twenty-four FOSACOF structures show average functionality, while six are still non-functional.

#### **Evaluation of Kole**

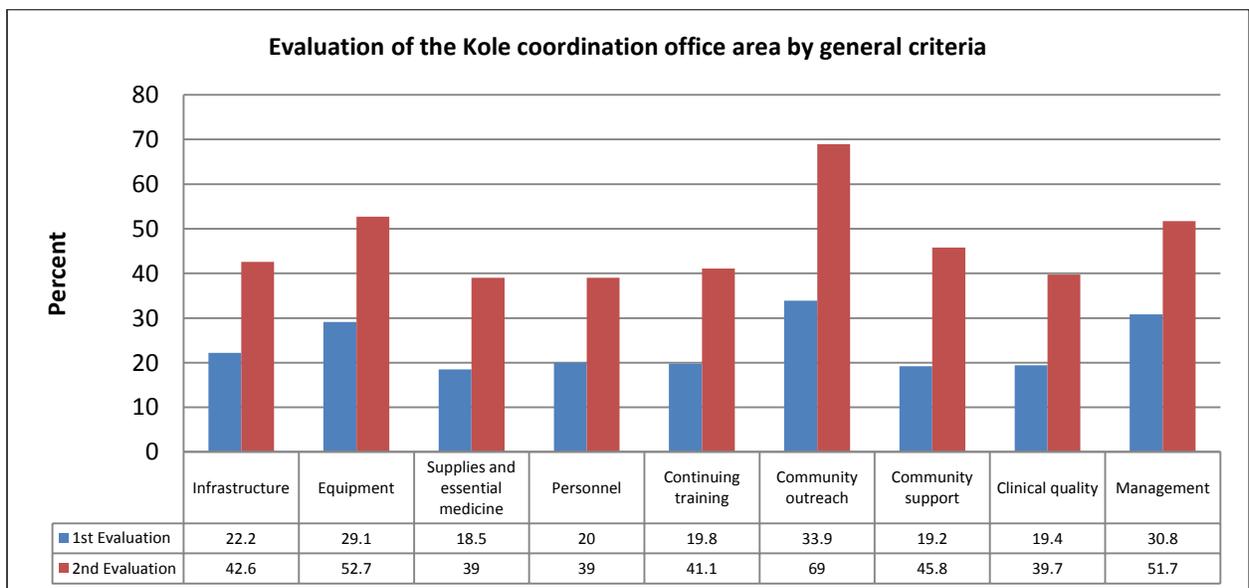
The Kole coordination office has 20 FOSACOF structures in four health zones. During this quarter, 17 structures were evaluated and three were not, due to inaccessibility during the evaluation period.

**Figure 8: Number of structures per FOSACOF performance class and per health zone in the Kole coordination office area in June 2011**



**Comments:** Six of the 17 structures, or 35.3%, were evaluated as being in the FOSACOF average functionality class, while 11 structures (64.7%) were in the non-functional FOSACOF class (Class C). No health zone has a structure in Class A. Revitalization efforts must be made in all of the FOSACOF structures with the Kole coordination's health zones, particularly in Kole, Tshudi Loto and Lomela.

**Figure 9: Evaluation of the Kole coordination area by general criteria**



### **Comments:**

All the evaluation criteria showed considerable improvement in the Kole coordination's second evaluation, and the community outreach criterion doubled due to the contribution of the community outreach agents. Nonetheless, more efforts are needed to ensure that the structures are completely functional; this will be done through increased field follow-up, regular evaluations, and implementation of a plan to revitalize the FOSACOF structures.

The other coordination offices have planned training and integration of FOSACOF methodology over the next quarter:

- Kamina and Kolwezi in July
- Bukavu and Uvira in August.

The IHP team supported the Health Zone Management Teams to carry out a basic assessment of the quality of the conditions in more than a third of the health facilities covered by the project. The assessment covered the availability of essential general medicine and the management of biomedical waste.

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

IHP supported two series of SNIS training in the Tshumbe coordination office, for members of the health zone management teams and service providers respectively. In May, training was provided to 32 members of the seven ECZs of the Tshumbe coordination office, including 3 women and 29 men (10 doctors, 8 health zone administrators, and 14 nurses). In June, 112 care providers were trained: 3 women and 109 men, both charge nurses (ITs) and nursing assistants (ITAs).

In the current reporting period, field visits focused on taking inventories and collecting health information as almost none of the target health zones were up-to-date with their SNIS reports. IHP also advocated for the Health Zone Management Teams to play a lead role in monitoring medical trainings. IHP technical teams participated in a meeting to consolidate, analyze and validate health data from May 2011 for 21 of the health zones in Bukavu, with the exception of Mulungu and Kalehe, due to insecurity issues. The Uvira office supported four of the five health zones to participate in this meeting, with the exception of Haut Plateau due to security issues.

## **I.1B (IR 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 4: Family Planning***

A shipment of contraceptives was received from USAID and sent to the eight coordination offices on April 25, 2011, with distribution as indicated in the following table:

**Table 3: Overview of contraceptive distribution by type**

CONTRACEPTIVES	QUANTITIES DISTRIBUTED	QUANTITIES ORDERED
<b>Depo Provera</b>	220,000 pieces	215,299 pieces
<b>IUD</b>	2,000 pieces	13,217 pieces
<b>Microlut</b>	20,160 cycles	20,160 cycles
<b>Microgynon</b>	411,840 cycles	165,838 cycles
<b>Jadelle</b>	1,000 pieces	19,212 pieces
<b>Condom/Male</b>	4,000,000 pieces	3,841,042 pieces
<b>Condom /Female</b>	100,000 pieces	80,044 pieces
<b>Cycle Beads</b>	70,000 pies	67,933 pieces

**Table 4: Quantities of contraceptives received and sent to the coordination offices**

Coordination office	Depo Provera	IUD	Microlut	Microgynon	Jadelle	Male condom	Female condom	Cycle beads
<b>Luiza</b>	32,200	300	2,880	51,120	100	500,000	13,000	15,000
<b>Mwene Ditu</b>	32,200	300	2,880	51,840	150	500,000	10,000	10,000
<b>Tshumbe</b>	24,800	200	2,160	51,120	100	500,000	13,000	10,000
<b>Kole</b>	24,800	200	2,160	51,120	100	500,000	12,000	10,000
<b>Kamina</b>	24,800	200	2,160	51,840	200	500,000	15,000	5,000
<b>Kolwezi</b>	24,800	200	2,880	51,840	100	500,000	13,000	5,000
<b>Uvira</b>	28,400	300	2,160	51,120	100	500,000	14,000	5,000
<b>Bukavu</b>	28,400	300	2,880	51,840	100	500,000	10,000	10,000

IHP family planning results in this quarter include the following:

New acceptors of modern method family planning increased to 130,733 in Q3 compared to 100,213 in Q2, and the number of counseling visits rose to 76,344 compared to 42,313 in Q2. These increases were in part due to the availability of products in the health centers and to the motivation of the community-based distribution (CBD) agents after receiving means of transportation (bicycles) late in the reporting period. The agents increased not only the number of their counseling visits, but also the number of villages and health areas visited.

In the seven health zones (Tshumbe, Minga, Katako Kombe, Djalo Ndjeka, Ototo, Dikungu, and Wembonyama), 256 CBDs were trained, an average of five CBDs per health area. At the present time, 1,748 CBDs are actively working in the 80 IHP-supported health zones. They are supervised by the charge nurses, who visit the CBDs once a month.

In late June, an initial lot of 125 bicycles was distributed to active CBDs, including 60 in the coordination offices of Mwene Ditu and 65 in the offices of Luiza, which have 504 and 424 CBDs respectively. A new order has been placed to cover the entire number of active CBDs in all the coordination offices.

Management tools were delivered to the coordination offices, and distributed in the form of individual sheets and reference tokens.

In the Kole coordination health zones, post-training follow-up and supervision were provided to 25 service providers trained in integrated mother and newborn care, and 132 active CBDs trained in family planning; the training took place May 22-24. The recommendations for mother and newborn care activities are as follows:

- The structures within the health zone must be rehabilitated, equipped and provided with materials, consumables and drugs, to support the service providers and thereby improve the quality of services.
- Training tools (module, checklist, image box, brochure) must be adapted in order to involve the traditional birth attendants (direct entry midwives) who are integrated into the structures.
- Instructional materials must be provided to the various offices and provinces to ensure post-training follow-up and formative supervision of service providers.

Findings and recommendations pertaining to the activities of the CBDs and community outreach:

- The CBDs are partially functional.
- The follow-up on reports and regular planning of CBD activities by the ITs are regular.
- Provide the CBDs with means of transportation, a raincoat and an umbrella as basic equipment, with distinctive signs so they can be identified in the community, and with other IEC material to facilitate their work.
- Conduct an evaluation of the quality of FP integration implementation at the treatment sites.
- Create pairs of educators among the CBDs (young people, men and women).
- Raise FP awareness through effective use of broadcast media.
- Train decision-makers and community leaders to understand the benefits of FP.
- Prepare and organize FP awareness campaigns in the community.
- Make FP management tools available to the CBDs.

Recommendations for FP service providers:

- Strengthen the capacity of service providers and management teams to manage reproductive health/contraceptive products.
- Enable the ITs and ECS members to carry out regular planning, follow-up and supervision.
- Train the “trainers” and then the service providers, on how to implement long-acting and permanent methods (LAPM): IUDs, implant, vasectomy and tubal ligation.
- Offer supervision to service providers in counseling on long-acting methods.

Mapping of family planning interventions in 80 health zones, in conjunction with the National Reproductive Health Program, C-CHANGE and UNFPA, is scheduled for the next quarter. This will help the Directorate of the national reproductive health program (PNSR) to achieve better coordination of FP activities and to meet unsatisfied FP needs, estimated at 27% according to the EDS 2007. It will also make it possible to improve management of products associated with reproductive health and family planning. This activity was planned in response to the national conference on FP repositioning that was held in Kinshasa December 8-9, 2009.

The results and the data collected through this activity will be presented in the next quarter.

USAID has organized a meeting to facilitate the exchange of experiences in implementing family planning activities and in community-based young people’s health. The meeting will take place in Nairobi, Kenya, from July 24 to 30, 2011. IHP will participate by sending a health zone supervisor and a community-based distributor with great experience in the field from the Luiza coordination office.

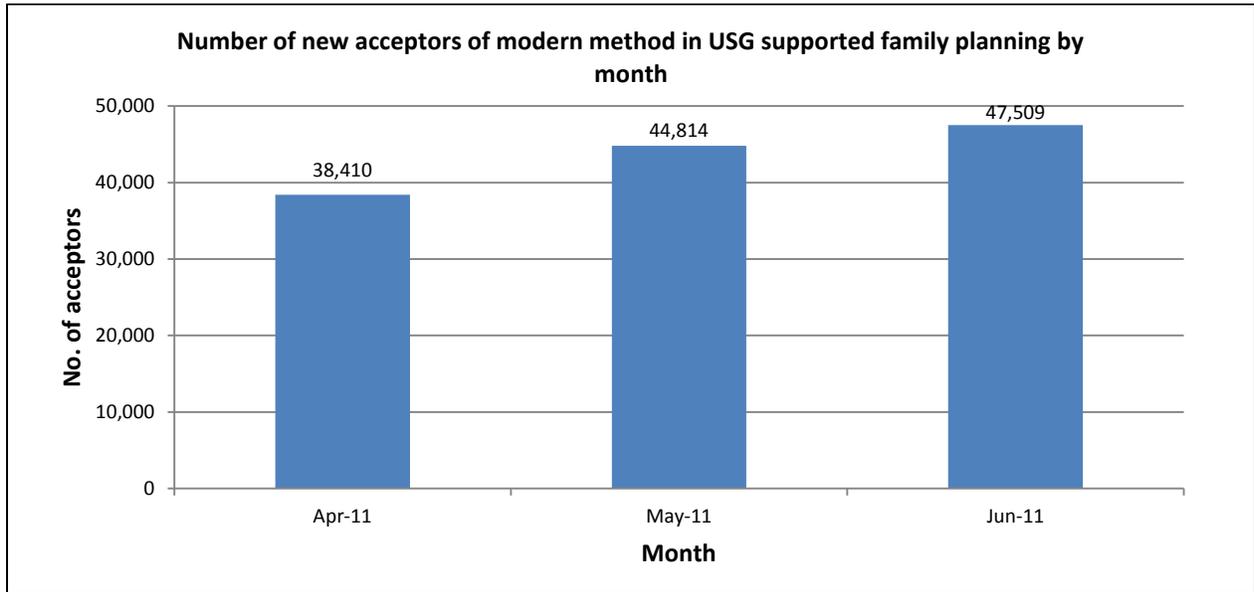
Preparation for the trip by the two representatives, and above all the presentation of the results obtained by IHP in the fields concerned, are part of the activities carried out in the period covered by this report.

During this quarter, IHP distributed 3,271 Tiahrt posters to the eight coordination offices, 1,775 in April and 1,496 in May, as indicated in the following table:

**Table 5: Number of Tiahrt posters distributed by coordination office**

<b>Coordination area</b>	<b>Number distributed</b>
Kole	308
Tshumbe	374
Mwene Ditu	543
Bukavu	390
Uvira	362
Kolwezi	299
Kamina	397
Luiza	607
<b>TOTAL</b>	<b>3,280</b>

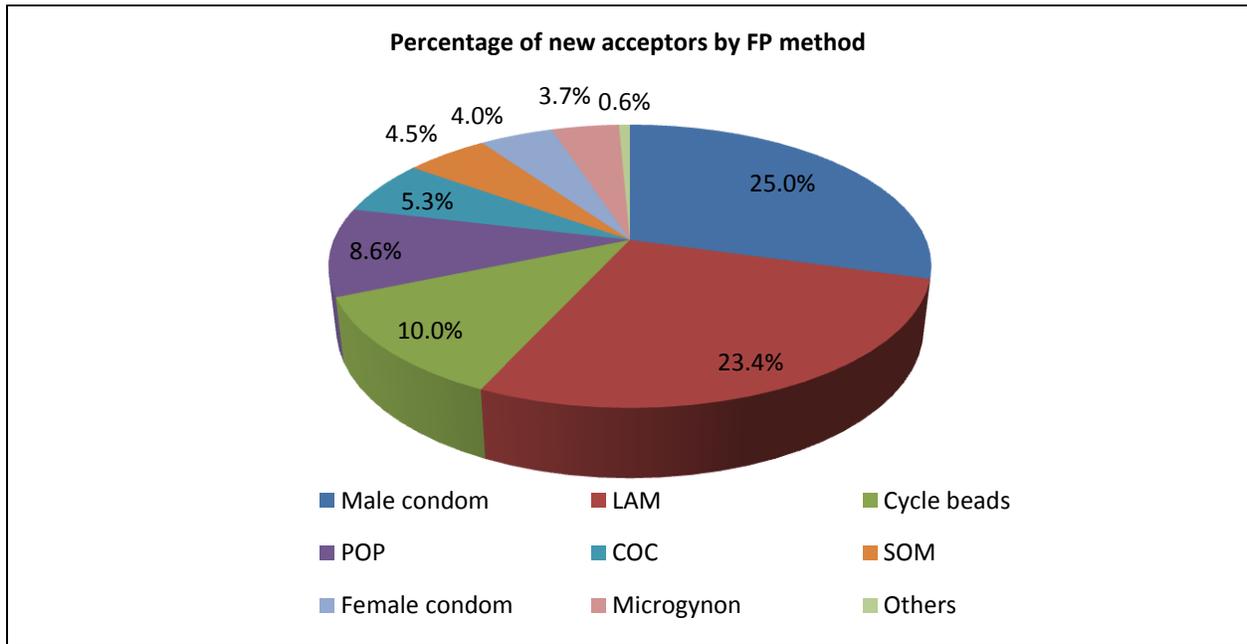
**Figure 10: Number of new acceptors of modern method in USG supported family planning clinics**



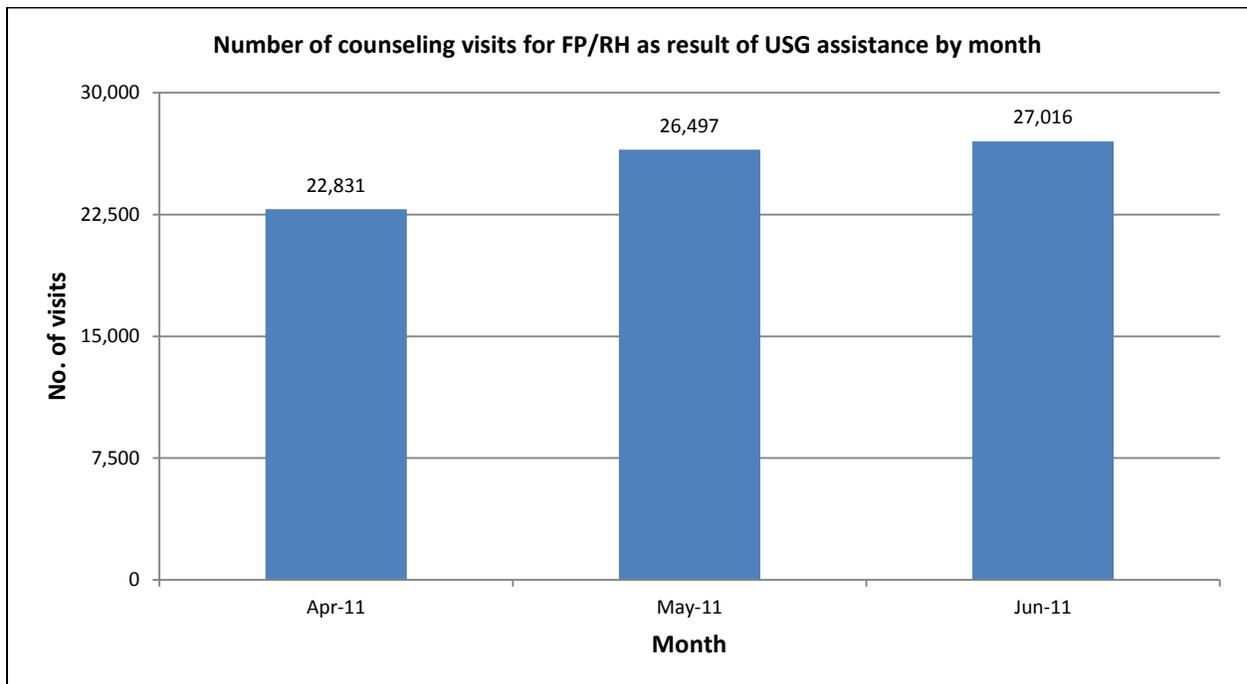
In this quarter, the number of new acceptors of modern clinical methods (requiring the presence of a service provider) declined by 38%, with 20,172 new acceptors vs. 32,477 in Q2, but there was a 30.4% increase in the number of acceptors of all modern methods combined: 130,733 in Q3 vs. 100,213 in Q2. This situation is explained by the fact that during the period, new acceptors adopted and used, to a much greater extent, the methods of self-observation, Lactational Amenorrhea Method, cycle beads and condoms.

During this reporting period, modern clinical methods accounted for only 15.4% of the total number of new acceptors (20,172 out of 130,733), while in the previous quarter, the proportion was 32.40% (32,477 out of 100,213). We are waiting for the results of the last quarter of this fiscal year to consider and analyze whether this downward trend has been influenced by such underlying causes as inadequacy in the informed choice of the methods concerned, uncontrolled rumors, unanswered questions regarding side effects and/or incomplete counseling.

**Figure 11: Family planning new acceptors by method**



**Figure 12: Number of counseling visits for FP/RH as a results of USG assistance**



Counseling visits increased by 80.4% compared to the previous quarter (Q2: 42,313; Q3: 76,344). A significant increase was noted in the two coordination offices of Luiza and Mwene Ditu, where, at the end of the reporting period, 125 CBDs received bicycles to make their rounds. In addition, education and mobilization campaigns, followed by home visits, were strengthened during the period.

As noted earlier, the IHP technical team is currently moving toward the integration of FP services into all the integrated health services (MNCH/FP), following discussions with and recommendations by a consultant who proposed that the following services be examined for potential integration: EPI, GMP, ANC, ENC, Postpartum, and HIV. This aspect of integration should start in the month of September.

IHP also decided to integrate the FP service into community treatment sites. This approach has been successful elsewhere, with experiences from other countries, such as Malawi, demonstrating the feasibility of the strategy). This integration of FP/CCM will be studied and included in the analysis of the CCM situation scheduled for August and September. It is clear that the persons responsible for the treatment sites (CCM) will need to be trained in FP, so that they can offer proper technical help and support to the CCM site in providing quality service to their clients. A guaranteed supply of contraceptives must also be available before greater expansion can take place. One suggestion has been studied, namely that the collaborative approach be applied and inserted, with a view to examining the possibilities of providing a high quality of service.

### ***Activity 5: Immunizations***

Noting the poor quality of vaccination data and the mediocre performance of the intervention zones, and concerned about improving these situations, IHP organized mid-level management (MLM) and data quality self-assessment (DQS) training in the Luiza coordination office. The training was attended by 25 managers from the 11 IHP-supported health zones, including 11 head zonal doctors, 11 supervising nurses and three EPI logistics experts.

In the Sankuru region, training in Expanded Program on Immunization (EPI) management was continued in the health training activities for nurses. In this quarter, a total of 364 service providers (322 men and 42 women) received training, specifically in the coordination offices of Tshumbe and Kole.

During the quarter, IHP regularly provided all health zones and EPI units with gasoline to operate 600 cold chain units, at a rate of 1.4 liters per day, as well as providing additional cold chain materials (wicks, glass and burners).

IHP ensured transportation of 4,686 kg of vaccines and inoculation materials from Kinshasa to Sud Kivu, at the request of the national directorate of the program.

IHP reproduced the tools for managing routine BENEFITING data for all the coordination offices: Forms 1, 2, 3, 4 and 5, tally sheets, and the vaccination register for routine EPI. Tally sheets for the integrated polio and vitamin A campaign in the province of Kasai Oriental were also provided.

In conjunction with their mass vaccination activities (such as support to national vaccination days), all IHP-supported health zones assisted with at least two campaigns against poliomyelitis. IHP staff took part in the various implementation processes for these activities, especially in the coordination offices. There was participation from all levels: the National Coordination Committee, the Provincial Coordination Committee, and the Local Coordination Committee. These processes included close supervision of the various health zones, deployment of the campaign's inputs to the health zones, and independent monitoring in the health zone of Ndekesha, Bilomba and Luiza. IHP supported the campaign against measles in 26 health zones: 21 in Sud Kivu, three in Katanga, and one each in Kasai Oriental and Kasai Occidental.

**Table 6: Cases of measles and deaths from measles by coordination, from EW14 to EW25 of the 2011 epidemic**

IHP coordination office	MEASLES	
	Cases	Deaths
Luiza	49	1
Mwene Ditu	10,137	144
Tshumbe	-	-
Kole	39	1
Kamina	1,068	3
Kolwezi	7,442	61
Uvira	1,101	3
Bukavu	41	1
<b>TOTAL</b>	<b>19,877</b>	<b>214</b>

**Table 7: Number of children vaccinated/vaccine coverage**

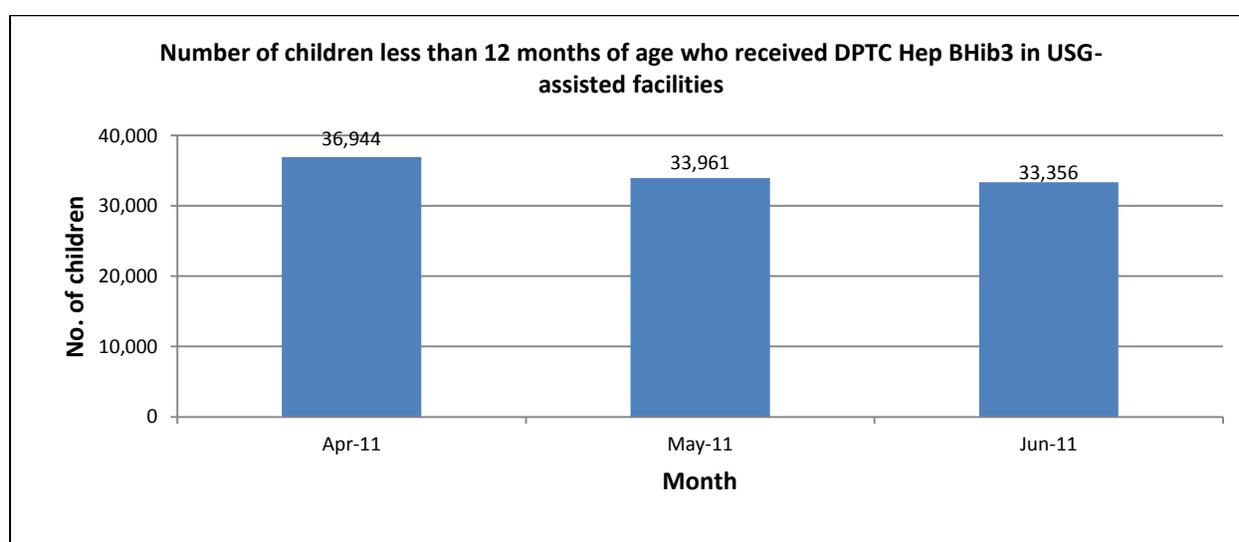
Provinces	Health zone	Number of children vaccinated	Vaccine coverage (%)
Sud Kivu	Bunyakiri	65,862	103.6%
	Ibanda	134,334	97.5%
	Idjwi	101,314	91.5%
	Kabare	79,596	99.8%
	Kadutu	127,073	125.7%
	Kalehe,	68,426	99.3%
	Kalole	47,700	97.7%
	Kalonge	63,234	105.9%
	Kamituga	66,375	99.5%
	Kaniola	71,613	96.5%
	Katana	87,067	104.0%
	Kaziba	49,631	100.3%
	Kitutu	59,621	99.0%
	Lulingu	67,222	99.7%
	Minova	96,771	103.1%
	Miti - Murhesa	97,120	101.1%
	Mwana	51,346	96.3%
	Mwenga	59,920	108.2%
	Nyangezi	57,642	95.0%
	Walungu	106,866	101.9%
	Hauts Plateaux d'Uvira	56,327	97.6%
Katanga	Kanzenze	47,438	113.4%
	Lubudi	47,491	98.9%
	Mutshatsha	29,530	94.6%
Kasaï Occidental	Tshikaji	50,934	83.8%
Kasaï Oriental	Mwene Ditu	172,156	98.3%

During the quarter, these 26 health zones organized the campaign against measles. Follow-up campaigns are planned for other health zones in the next quarter.

**Table 8: Analysis of vaccination date for the first quarter of 2011 – IHP health zones (see Annex 5 for details)**

Analysis of vaccination data for the first quarter of 2011 – IHP health zones			
Province	Health zones	Category	Total
Kasaï Occidental	11	Category 1	1
		Category 2	2
		Category 3	3
		Category 4	4
Kasaï Oriental	24	Category 1	18
		Category 2	2
		Category 3	1
		Category 4	3
Katanga	17	Category 1	8
		Category 2	4
		Category 3	4
		Category 4	1
Sud Kivu	28	Category 1	17
		Category 2	6
		Category 3	3
		Category 4	2

**Figure 13: Number of children less than 12 months of age who received DPTC Hep BHib3**



The decrease in the number of children less than 12 months of age who received DPTC Hep BHib3 in June, compared to April, is not a matter of concern, for the following reasons:

1. The figure obtained in April (36,944) is due to the recovery of the children in the health zones supported by IHP who were not vaccinated due to the stock-out of antigens in March.
2. The figure of 33,356 is slightly lower than the monthly target population because the health zones of Bunkeya (Kolwezi) and Mulungu (Sud Kivu) were unable to send in their data for the month of June.

### ***Activity 6: Mother, child, and neonatal health***

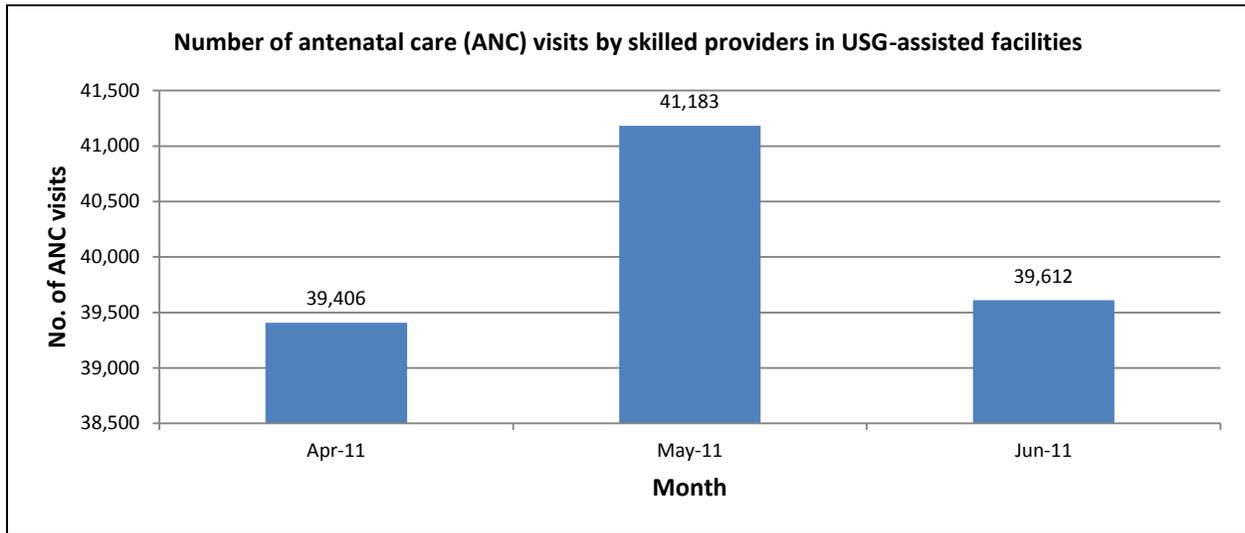
From May 5 to 26, training on integrated mother and newborn care was provided in Dekese. There were 30 participants in all (four women and 26 men), including 18 charge nurses (IT) out of the 19 in the health zone, three assistant nurses (ITA), two supervising nurses from the zone's central office, two locally referred midwives, and five doctors. In all the health structures of the health zone, deliveries are primarily directed by the traditional birth attendant (TBA), but because of their prerequisites level, the TBAs could not be selected for this training.

The approach "master to understand" was used during the training, so that all participants could master the necessary knowledge, skills and attitudes. The ultimate purpose of the training was that 100% of the persons trained would master the knowledge and skills dispensed during this course and thus be able to take good care of mothers and newborns.

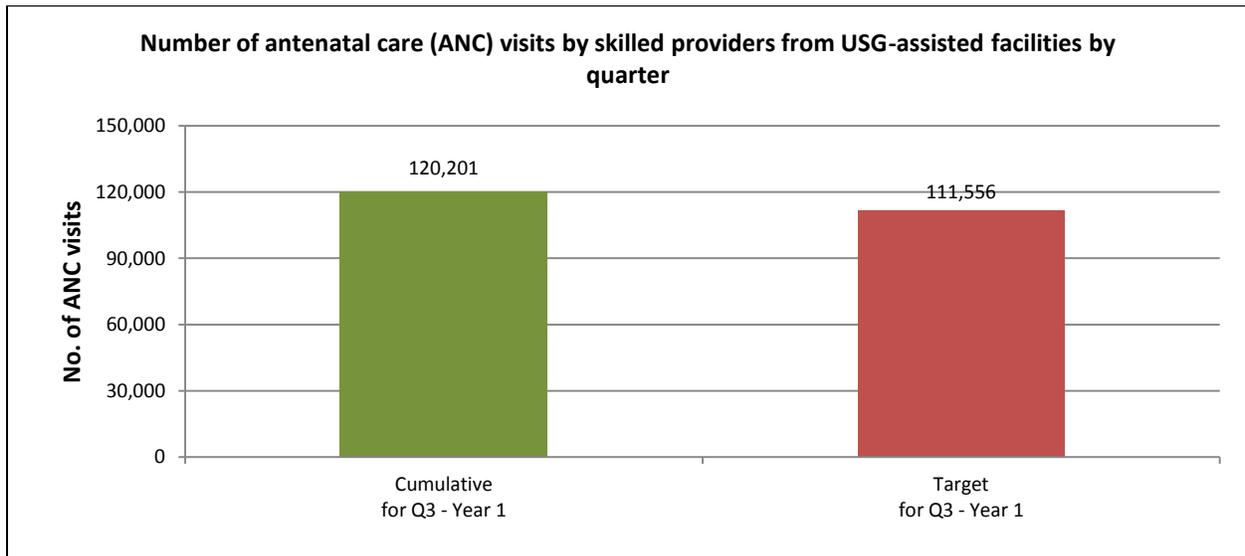
Training in KMC (Kangaroo Mother Care) began implementation this quarter and will continue into the next. Preparations for KMC training were begun in June, in collaboration with the 10th directorate of the Ministry of Health and the MCHIP Project. These preparations included identification of participants, and finalizing instructional materials and related documents. The details of this training will be presented in the next quarter.

A new maternal and newborn health advisor who will focus on integrated maternal and newborn care, Active Management of Third Stage Labor (AMTSL), and eclampsia will join the IHP technical team early in the next quarter. IHP has hired an international consultant with expertise in these areas to orient the new staff member, train the technical staff, review the official documents relating to these technical areas, and advise the project team on the development of these activities for project year two.

**Figure 14: Number of antenatal care (ANC) visits by skilled providers from USG-assisted facilities**

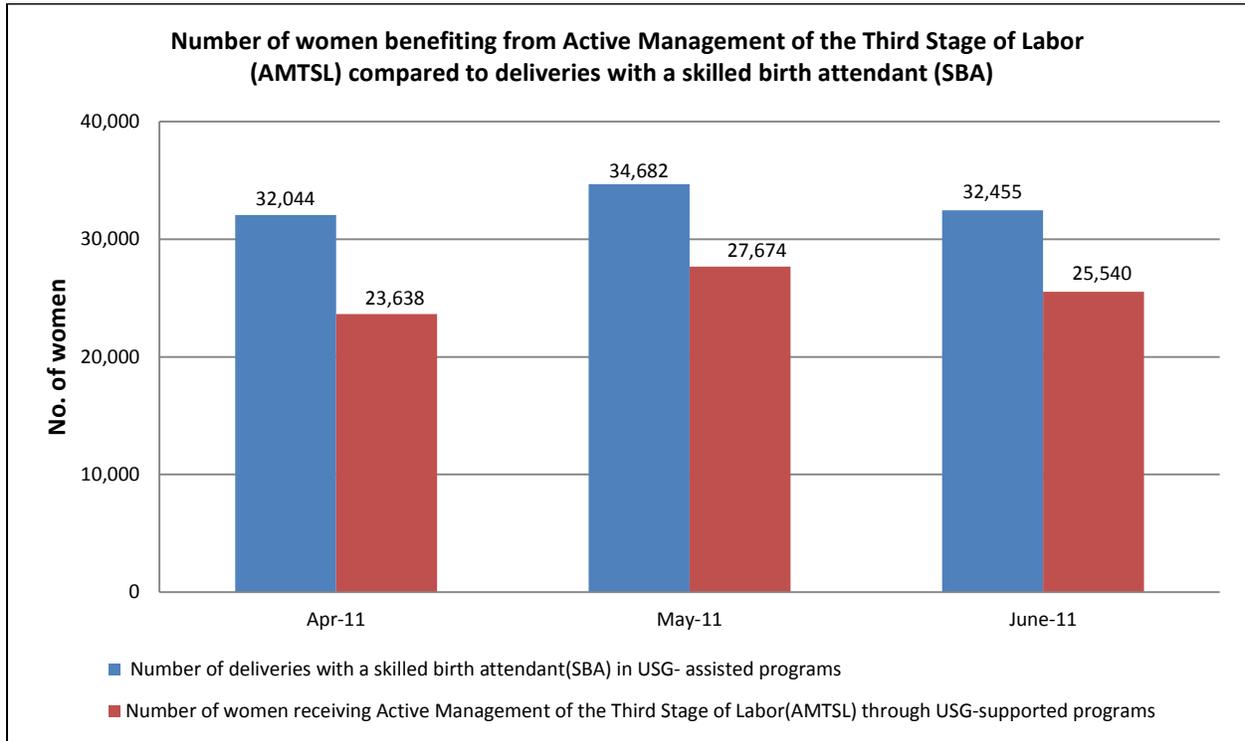


**Figure 15: Actual cumulative vs. target number of ANC visits by skilled providers from USG-assisted facilities**



The slight decrease in the ANC rate is attributed to the health zones that organized campaigns against measles in the province of Kasai Oriental, and more specifically those of the health districts of Mbuji Mayi and Mwene Ditu, since staff were frequently outside the health facilities to carry out campaign activities.

**Figure 16: Number of women benefiting from Active Management of the Third Stage of Labor (AMTSL) compared to deliveries with a skilled birth attendant (SBA)**



During the quarter, 76,852 of 99,181 of women who delivered at health facilities had a skilled birth attendant present at their delivery; this equates to around 77% coverage for AMTSL. This figure represents a 50% increase in the number of women benefiting from AMTSL this quarter, compared to the previous quarter (76,852 in Q3 vs. 51,158 in Q2).

**Activity 12: Distribution of IPT and LLINs**

IHP continues to distribute insecticide treated nets provided by the President’s Malaria Initiative (PMI) in the 80 project supported health zones. The following table shows the distribution for this quarter.

**Table 9: Distribution of LLINs distributed in Q3Y1, per IHP coordination office and per province**

Province	IHP coordination office	Number of health zones	Number of Insecticide Treated Nets distributed that were purchased or subsidized with USG support			
			11-Apr	11-May	11-Jun	Q3Y1
Kasaï Oriental	Kole	7	3,101	1,329	3,906	8,336
	Tshumbe	6	17,033	29,773	25,283	72,089
	Mwene Ditu	11	6,459	6,285	6,319	19,063
Kasaï Occidental	Luiza	11	5,886	7,255	6,529	19,670
Sud Kivu	Bukavu	23	0	0	40,736	40,736
	Uvira	5	0	0	9,600	9,600
Katanga	Kolwezi	8	0	0	6,311	6,311
	Kamina	9	942	7,175	4,490	12,607
<b>TOTAL</b>		<b>80</b>	<b>33,421</b>	<b>51,817</b>	<b>103,174</b>	<b>188,412</b>

Overall, 188,412 LLINs (94% of planned) were distributed in Q3. The distribution process is continuing on the basis of the previously established plan. The coordination offices of Bukavu, Uvira and Kolwezi began distribution at the end of the quarter. The Mulingu health zone has not yet received its LLINs because of logistics problems associated with its difficult accessibility.

The next table presents the quantities of LLINs distributed from October 2010 to June 2011, both by IHP and other partners.

**Table 10: Distribution of LLINs distributed by province, coordination office, partner and target from October 2010 to June 2011 in the health zones supported by IHP**

Province	Coordination office	No. of HZs	LLINs distributed by IHP			LLINs distributed by other partners		
			For children < 5 years	For pregnant women	Total	For children < 5 years	For pregnant women	Total
Kasaï Oriental	Kole	7	13,971	9,389	23,360	3,815	5,002	8,817
	Tshumbe	6	13,915	9,227	23,142	N/A	N/A	0
	Mwene Ditu	11	1,780	68,879	70,659	20,554	0	20,554
Kasaï Occidental	Luiza	11	14,721	15,355	30,076	16	1,773	1,789
Sud Kivu	Bukavu	23	0	40,736	40,736	ND	ND	0
	Uvira	5	0	9,600	9,600	ND	ND	0
Katanga	Kolwezi	8	0	6,311	6,311	ND	ND	0
	Kamina	9	2,040	16,529	18,569	ND	ND	0
<b>TOTAL</b>	<b>8</b>	<b>80</b>	<b>46,427</b>	<b>176,026</b>	<b>222,453</b>	<b>24,385</b>	<b>6,775</b>	<b>31,160</b>

As of June 2011, a total of 222,453 LLINs had been distributed in the 80 IHP health zones in the four provinces. The process is continuing on the basis of availability of stock, and in accordance with the distribution plans. The LLINs are for the most part (79%) distributed to pregnant women at the time of their antenatal consultations (ANC).

In addition, the coordination offices provided the following information about the LLINs distributed by other partners in our intervention zones; some coordinations were not able to provide this information:

- In the Mwene Ditu coordination office, 20,554 LLINs were distributed by other partners, including 492 LLINs by UNICEF in the Kamiji health zone; 4,241 LLINs by the Global Fund in the Kandakanda health zone; 10,029 LLINs by the Global Fund in the Mwene Ditu health zone; and 5,792 LLINs by the Global Fund in the Dibindi health zone.
- In the Kole coordination office, 8,817 LLINs were distributed by other partners, including 2,414 LLINs by the Global Fund in the Omendjadi health zone; 3,988 LLINs by the Global Fund in the Lodja health zone; 1,116 LLINs by the Global Fund in the Benadibele health zone; and 1,299 LLINs by the Global Fund in the Kole health zone.
- In the Luiza coordination office, 1,789 LLINs were distributed by the Global Fund for pregnant women, essentially in the Mutoto health zone.

The following table provides the quantities of Sulfadoxine-Pyrimethamine (SP) for Intermittent Preventive Treatment during Pregnancy (IPT) distributed during this reporting period.

**Table 11: Management of SP stock for IPT in the IHP-supported health zones, Q3**

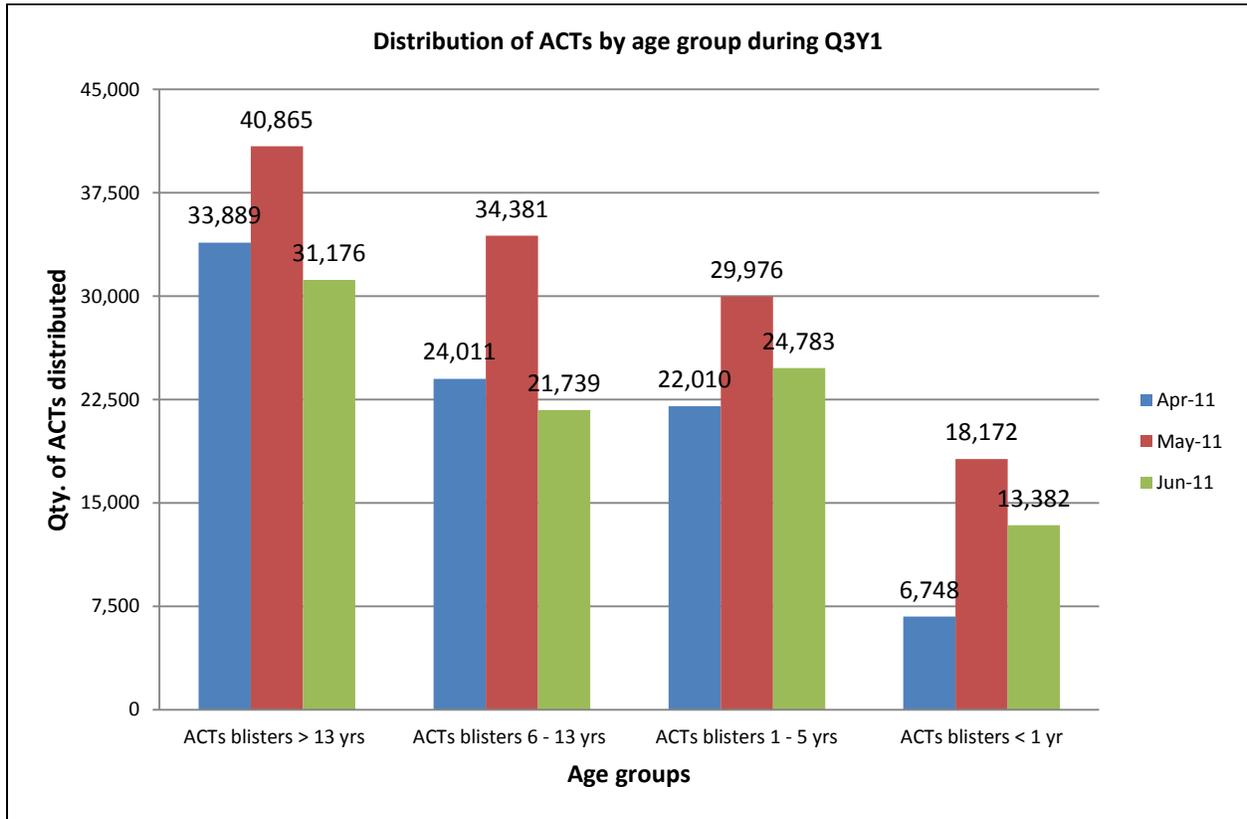
SP	Apr-11	May-11	June-11
Current stock	402,981	449,612	428,901
Quantity consumed	122,953	165,444	129,380
# structures with stock-outs	527	395	346

Distribution of SP was effective in the quarter, except for the cases of stock outs experienced at the beginning of the quarter in the coordination offices of Kamina, Kolwezi, Uvira and Bukavu, in particular due to the fact that certain zones were not accessible. The proportion of health care structures that experienced a stock-out is 0.2% to 0.3%.

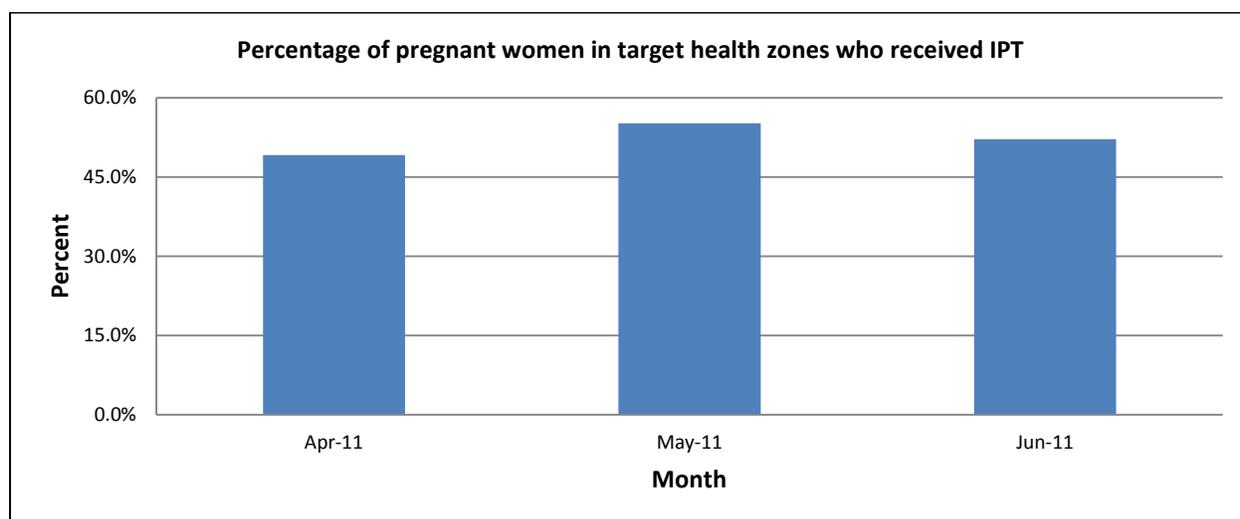
**Activity 18: Malaria**

The quantities of Artemisinin Combination Therapies (ACTs) distributed per presentation during this quarter are presented in the following figure:

**Figure 17: Distribution of ACTs distributed in Q3Y1, by presentation and age group, in the health zones supported by IHP**



**Figure 18: Percentage of pregnant women in IHP target health zones who received Intermittent Preventive Treatment (IPT) for malaria**



As illustrated in the figure above, on average, half of the women in IHP's target health zones received IPT during their ANC, in accordance with the national protocol. Because of some stock-outs that occurred in areas such as Kamina, Kolwezi, Uvira, Bukavu, etc., this rate is slightly lower than the rate for the previous quarter (55%), though it is comparable to the rate for 73 health zones that received support from the Global Fund for Round 3 (51.2%).

The following table shows the percentage of pregnant women who received at least two doses of SP during ANC, in the health zones supported by IHP.

**Table 12: Distribution of IPT in quarter Q3Y1, by coordination office and province, in the health zones supported by IHP**

Province	Coordination office	Number of health zones	IPTI 2 Average April, May and June
Kasaï Oriental	Kole	7	68.9 %
	Tshumbe	6	66.8 %
	Mwene Ditu	11	69.4 %
Kasaï Occidental	Luiza	11	58.8 %
Sud Kivu	Bukavu	23	39.7 %
	Uvira	5	42.6 %
Katanga	Kolwezi	8	18.9 %
	Kamina	9	49.0 %
<b>TOTAL</b>	<b>8</b>	<b>80</b>	<b>52.0 %</b>

Table 12 shows that nearly half the coordination offices have rates around 60-69%, and that this average is obscured by the low rates of Kolwezi (18.9%) and Bukavu (39.7%) especially.

Furthermore, in comparison with the previous quarter, the health zones of the following coordination offices have made real progress: Mwene Ditu, where the IPT rate rose from 61.7% to 69.4%; and Tshumbe, where the IPT rate increased from 62.9% to 66.8%. In contrast, some coordination offices turned in a substandard performance, particularly in Kolwezi, where the IPT rate fell from 30.7% to 18.9%, and in Kamina where it dropped from 61% to 48.9%. This low IPT rate is apparently due to SP stock-outs, as happened in Kamina, but also and above all to an internal failure to complete data, as in Kolwezi and Bukavu.

Training in the use of RDTs is planned for Bukavu, Uvira and Kolwezi in September, and for Luiza in late July.

During this quarter, IHP benefited from the support of SPS to offer training of trainers (TOT) to the management teams in the health zones supported in the occidental province. This training concerned management of malaria in accordance with the new PNLP policy, which includes doing rapid diagnostic tests (RDTs). On May 17 and 18, 2011, a total of 22 persons received training as trainers, including 10 head zonal doctors, 10 supervising nurses, one GRH chief physician and one supervising physician of the PNLP. The training was facilitated by a mixed SPS-PNLP-DPS team.

Ten of the eleven health zones covered by the Luiza coordination office benefited from this training, namely Kalomba, Ndekeshia, Bilomba, Yangala, Tshikaji, Mutoto, Lubindaie, Dibaya, Bulape and Katoka. The Dekese health zone was unable to attend the training because the information about it was not communicated in time. Trainers and service providers will be trained in the next quarter. Moreover, since the Luiza health zone has already received this training of trainers, it has been replaced by the Katoka health zone, which benefited from PMI inputs in the past. The results obtained suggest that the individuals who receive the training are able to lead a workshop on malaria management, to treat cases of malaria properly in accordance with the new protocol, and to perform and correctly interpret the rapid diagnostic test for malaria.

The next step is to organize the training of service providers in each health zone. The coordination offices of Kolwezi in the province of Katanga and of Bukavu and Uvira in the province of Sud Kivu have planned for a TOT session during the next quarter.

IHP provided logistical support to the Improving Malaria Diagnostics (IMaD) project for the training it offered on good microscopy practices and scopes of work for lab technicians at general referral hospitals.

Since the last quarter, IHP paid for the distribution of Artemisinin-based Combination Therapies (ACTs) and Rapid Diagnosis Tests (RDTs).

### ***Activity 20: Nutrition rehabilitation***

During this period, only the Luiza coordination office provided data on nutrition. Nutrition rehabilitation activities, strictly speaking, have been integrated to date only in the health zones of Dibaya, Tshikaji, and Bilomba. Detection of malnourished children is done systematically during preschool counseling (PSC), with some cases of weighing in the community by community health workers (RECO). In May, the

number of children receiving vitamin A supplements increased considerably as a result of the campaign (1,416,668). The following table presents the numbers of cases of malnutrition among children and pregnant women in the IHP coordination offices. Malnutrition is defined here for children 0-59 months as W /H < -3 ET, mid-upper arm circumference (MUAC) < 115 mm; and for pregnant women as mid-upper arm circumference (MUAC) <180 mm.

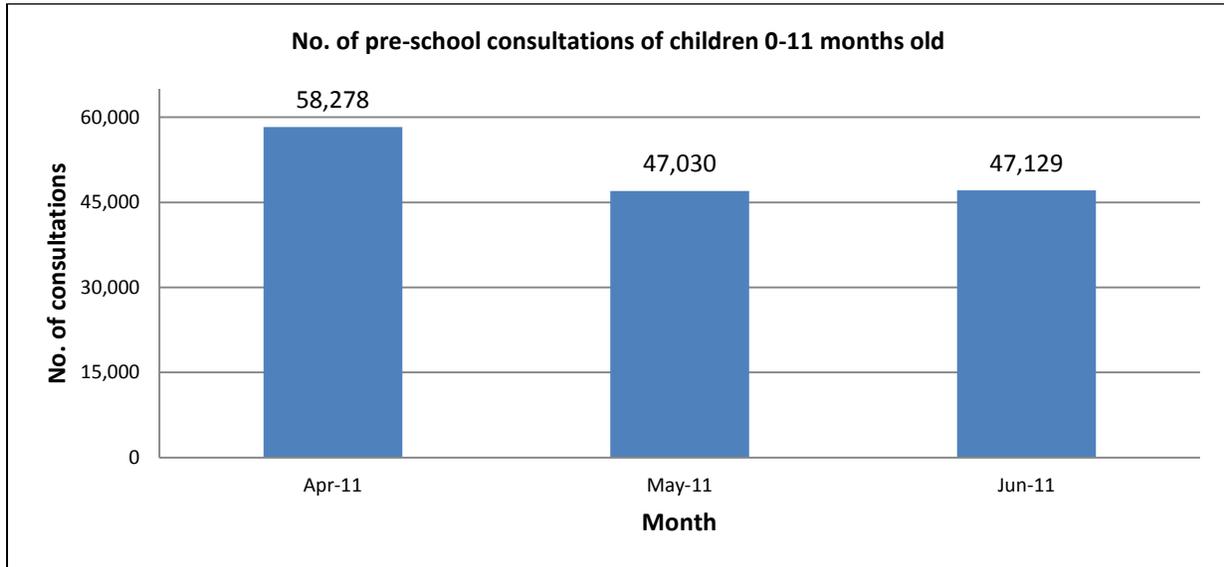
**Table 13: Changes in cases of malnutrition in IHP-supported health zones from April to June 2011, among pregnant women and children 0-59 months of age**

Target	Period		
	April	May	June
# Children 0-11 months PSC	58,278	47,030	47,129
# Children 12-59 months PSC	43,986	52,190	49,132
# Children 0-59 months with stage 1 malnutrition (light)	9,882	12,664	10,224
# Children 0-59 months with stage 2 malnutrition (moderate)	6,852	9,192	4,256
# Children 0-59 months with stage 3 malnutrition (severe)	3,365	2,854	2,260
# Children 0-59 months with stage 2 malnutrition (moderate) PEC	6,073	4,680	3,752
# Malnourished pregnant women	623	401	403
# Malnourished pregnant women PEC	305	156	292
# Children 0-6 receiving breastfeeding exclusively	14,487	11,684	11,265

**Comments:**

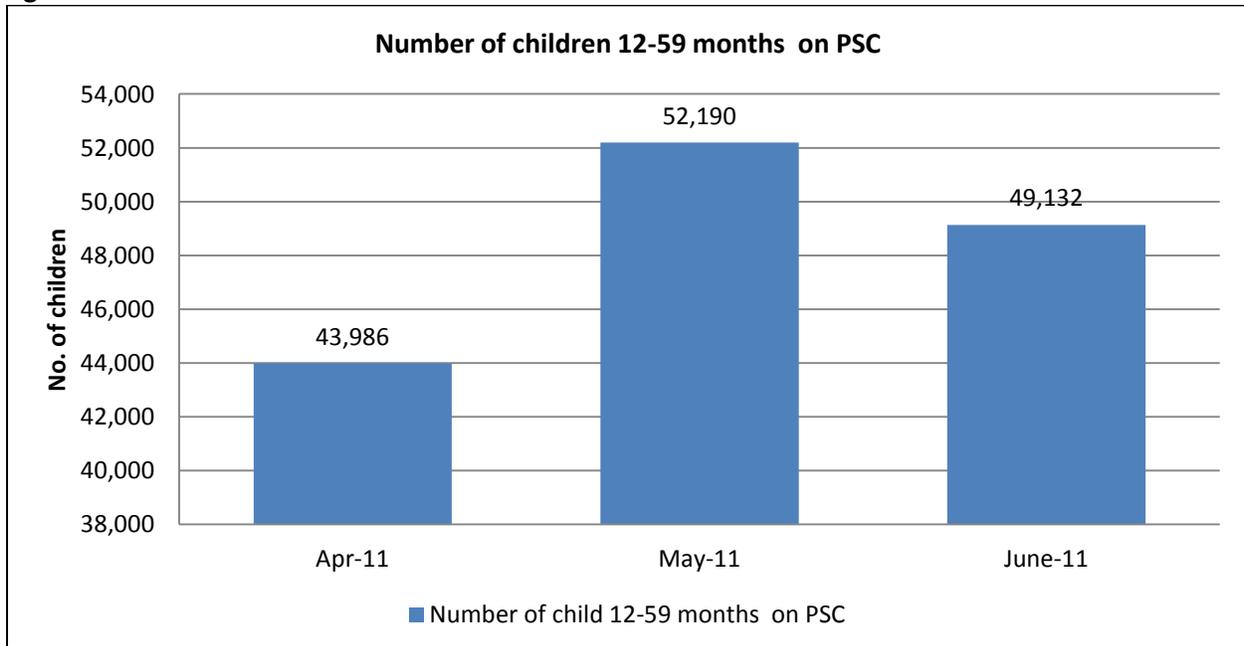
This table provides some useful nutrition indicators, as reported and compiled for all the health zones supported by IHP; however, future reporting will need to include additional key indicators such as the number of cases treated, cases cured, number of deaths, and number of cases of abandonment. IHP will reinforce the need for these data with the coordination offices in the next reporting period.

**Figure 19: Number of pre-school consultations (PSC) among children aged 0-11 months in IHP target areas**



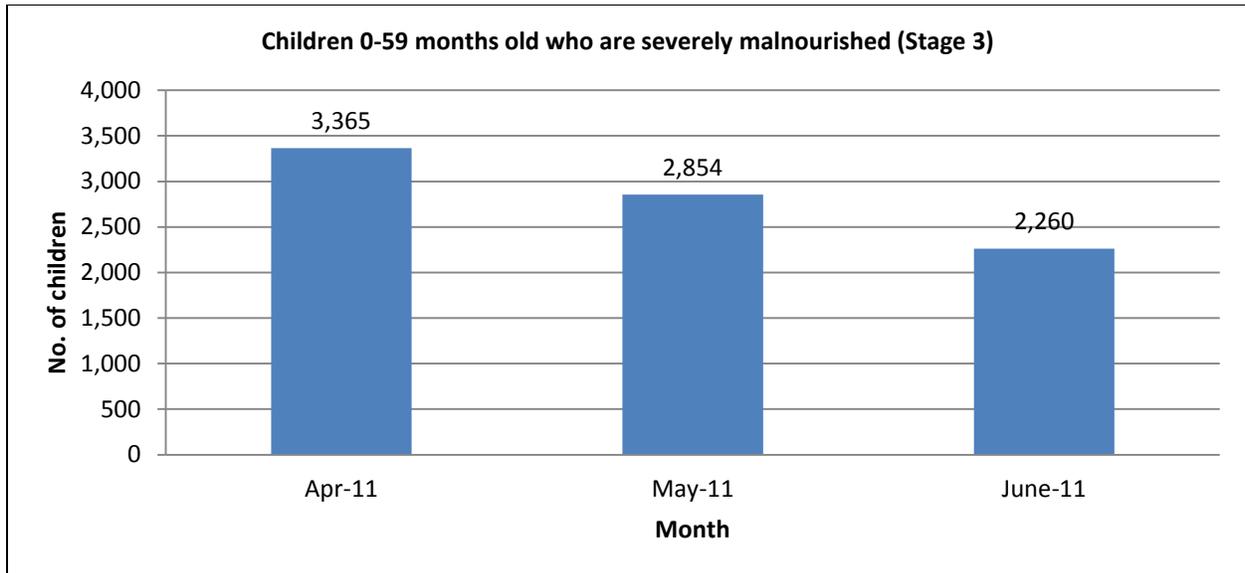
**Comments:** Pre-school consultations include weighing, taking the measurement of the child, vaccinations, nutritional status check up, and distribution of LLITNs. During this reporting period, health centers received visits from 152,437 children less than 11 months old, versus 118,581 children expected in the quarter (assuming that children 0-11 months of age represent approximately 4% of the population), representing a percentage of 128.55%. The numerator exceeds the denominator, which may mean that there are children attending from other health areas or that some children may have been counted twice during the reporting period. There was high attendance in April, compared to the other months.

**Figure 20: Number of children 12-59 months on PSC**



**Comments:** The number of children age 12 to 59 months (estimated to be 15% of the total population, or 444,678) expected to attend preschool consultation aged 12 to 59 months was 148,226 children; 145,308, or 32%, actually attended.

**Figure 21: Children aged 0-59 months that are severely malnourished**



**Comments:** Based on information provided in a nutritional study conducted in 2009 by the National Nutrition Program, funded by UNICEF, IHP expected to find about 10% (52,290) of Global Acute Malnutrition (GAM) for children between 0-59 month (who make up about 20% of the total population). However, routine data collection on children presenting with GAM showed that 8,479 children, or 42.9% of those attending health facilities, were affected with severe (acute) malnutrition.

The data indicate that we have a serious nutrition challenge in the four provinces of the project. While the new national protocol on case management has been introduced only in a few health zones—such as Lomela, Ototo, Omendjadi, and Lodja—IHP expects that the wider implementation of the protocol for integrated management of malnutrition (PCIMA) will increase the number of cases identified through both active (at the community level\_) and passive screening (completed by health workers at the health centers).

**Activity 33: Oral rehydration therapy and diarrheal disease control**

In the 80 project-supported health zones, IHP contributed to the distribution and promotion of MOH directives concerning the use and storage of zinc sulfate for case management of diarrhea in children under 5. The health facilities are ensuring regular distribution of zinc sulfate and ORS as part of the health zone requisition for essential drugs and medical supplies.

**Activity 41: Leadership Development Program (LDP)**

The Leadership Development Program (LDP) develops leadership and management practices for organizations through a process of learning in action. Participants learn leadership by starting with their own experiences and with the real challenges they confront in their place of work over time. The

feedback and support they receive enables them to use these practices to meet their challenges and to obtain measurable results. This method of leadership development is different from the traditional training programs, which introduce theories, values and leadership behaviors via methods that do not allow the teams to make the connection between this learning and obtaining measurable results for the organization.

A results-based LDP alignment workshop was organized in Kinshasa for IHP staff and the Ministry of Health. The workshop was attended by 18 people: five members of the MOH and 13 IHP staff (4 women and 14 men).

Training of trainers in LDP was held in Bukavu from April 14 to 19. Participants included three IHP staff members from Bukavu and Uvira, one from IRC, one person from the Bagira-Kasha health zone, and 17 people from the provincial health directorate. The training was followed by a high-level alignment meeting attended by 47 participants, including 25 facilitators and 22 other participants from the local political and administrative authorities.

During the period, five LDP workshops, took place in Sud Kivu for health zone clusters from Walungu (1 workshop), Bukavu (2 workshops), Mwenga (1 workshop) and Uvira (1 workshop) respectively. They brought together, on average, five members of the health zone management teams and four persons from the corresponding health districts. In total, 135 participants from 27 health zones participated in these workshops; representatives from Mulungu did not participate due to problems with insecurity.

In June 2011, IHP organized a training of trainers in LDP at Kananga, for 25 members of the provincial health division of Kasai Occidental (three women and 22 men). This training was followed by a high-level alignment meeting in which 47 people participated, including 25 facilitators and 22 persons from the local political and administrative authorities.

In addition, the LDP Workshop 1 was held for the health zones of Tshikaji, Mutoto, Bulape, Lubodaye and Dekese. There were 25 participants (one woman and 24 men).

An LDP training session was held in Mbuji Mai from June 22 to 28, for the health zones of Bibanga, Dibindi, Pania Mutombo, Lusambo and Mpokolo. The training was attended by 22 participants (three women and 19 men) from the provincial health division. This was followed by the Workshop 1, which had 28 participants (one woman and 27 men).

**Table 14: Distribution of participants by province and by type of activity**

	Sud Kivu			Kasai Oriental			Kasai Occidental		
	M	W	TOTAL	M	W	TOTAL	M	W	TOTAL
<b>Training of trainers (TOT)</b>	25	0	<b>25</b>	19	3	<b>22</b>	22	3	<b>25</b>
<b>Senior Alignment meeting (SAM)</b>	45	2	<b>47</b>	0	0	<b>0</b>	50	14	<b>64</b>
<b>Workshops 1</b>	138	1	<b>139</b>	27	1	<b>28</b>	24	1	<b>25</b>
<b>GRAND TOTAL</b>	<b>208</b>	<b>3</b>	<b>211</b>	<b>46</b>	<b>4</b>	<b>50</b>	<b>96</b>	<b>18</b>	<b>114</b>

**Table 15: Participants in LDP workshops in Sud Kivu, by district and health zone**

PROVINCE OF SUD KIVU									
District Bukavu		District Walungu		District Ouest		District Nord		District Sud	
Health zone	# of people	Health Zone	# of people	Health Zone	# of people	Health Zone	# of people	Health Zone	# of people
Ibanda	5	Kaziba	5	Shabunda	5	Idjwi	5	Nundu	5
Bagira-Kasha	5	Walungu	5	Kamituga	5	Kalonge	5	Lemera	5
Miti-Murheza	5	Mubumbano	5	Kitutu	5	Minova	5	Plateau	5
Kadutu	5	Mwana	5	Mulungu	5	Bunyakiri	5	Ruzizi Plain	5
Katana	5	Nyangezi	5	Mwenga	5	Kalole	5	Uvira	5
		Kaniola	5			Lulingu	5	Ds Sud	4
<b>TOTAL</b>	<b>25</b>		<b>30</b>		<b>25</b>		<b>30</b>		<b>29</b>

**Table 16: Participants in LDP workshops in Kasai Oriental, by district and health zone**

PROVINCE OF KASAI ORIENTAL					
District Mbuji-Mayi		District Sankuru		District Tshilienge	
Health zone	# of people	Health zone	# of people	Health zone	# of people
Mpokolo	5	Lusambo	5	Bibanga	5
Dibindi	5	Mpanya-Mutombo	5		
DS Mbuji-Mayi	3				
<b>TOTAL</b>	<b>13</b>		<b>10</b>		<b>5</b>

**Table 17: Participants in LDP workshops in Kasai Occidental, by district and health zone**

PROVINCE OF KASAI OCCIDENTAL					
District Kananga		District Kasai		District Lulua	
Health zone	# of people	Health zone	# of people	Health zone	# of people
Tshikaji	5	Dekese	5	Lubondaie	5
Mutoto	5	Bulape	5		
<b>TOTAL</b>	<b>10</b>		<b>10</b>		<b>5</b>

**Activity 45: Disease surveillance: TB, NTDs, etc.**

As part of the efforts to combat tuberculosis, a meeting was planned with the National Program on June 7, 2011. The main discussion points focused on:

1. A request for support in planning the workshop to validate the HIV/TB co infection guide. The point was made that consultation between the national program to combat tuberculosis and the national program to combat AIDS is a prerequisite to submitting any official request to IHP.
2. Discussion on harmonizing interventions between the national program and IHP. It was decided that a working meeting would be scheduled for late July, to involve the two entities and the other partners in the fight against tuberculosis.

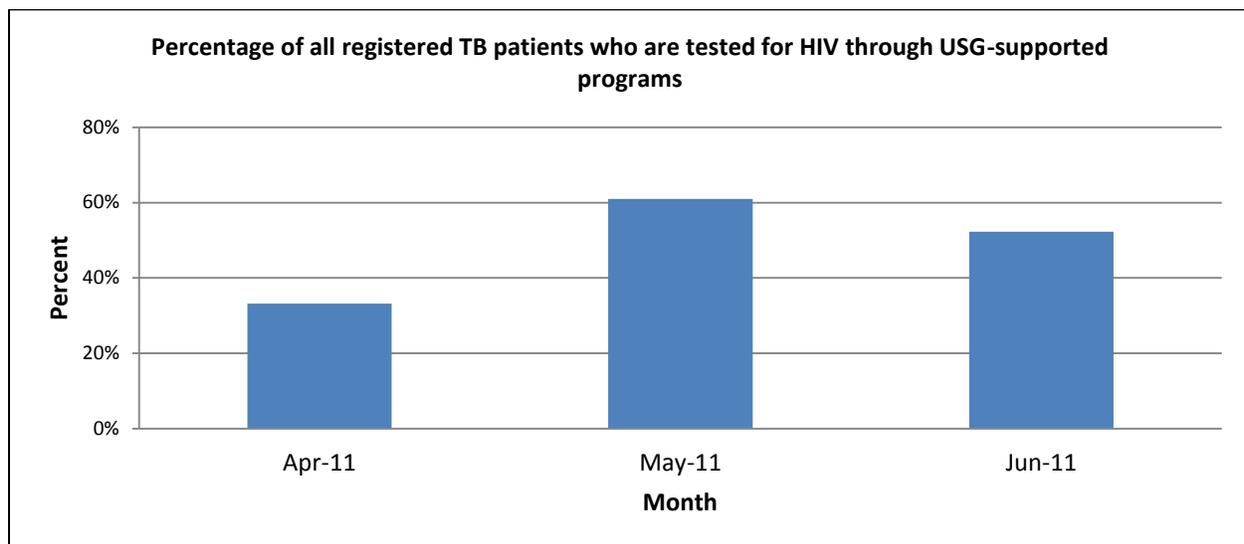
IHP has developed a plan to strengthen the capacities of community health workers and of Friends of Damien clubs as a priority for the health areas with low detection (particularly in Sud Kivu).

IHP also developed a plan to supervise the provincial tuberculosis control coordination offices (CPLT) and the health zones during the period from July to September, in order to identify the efforts made and the gaps to be filled.

IHP held a meeting with TB CARE and MSH/SPS on May 5, 2011, during which the following items were addressed:

1. Harmonization of activities and approaches as USAID funded projects.
2. Strategies on how to best work together with the National TB Control Program (PNLT) for its strengthening.
3. Agreement on “TB 2015” to sponsor two people from the PNLT to the upcoming Workshop (19-21 July 2011) on MDR TB in Johannesburg, South Africa, and possibly the SPS Senior Program Associate in charge of TB for the same workshop.
4. Development of an action plan to conduct audits of the data in Sud Kivu between IHP and TB CARE (technical assistance) in the next quarter.

**Figure 22: Percentage of all registered TB patients who are tested for HIV through USG-supported programs**



The low percentage of TB patients who were tested for HIV (co infection) can be attributed to stock-outs of inputs during the period, and when the quantity borrowed by IHP arrived, the distribution prioritized the needs of the PMTCT sites, leaving the co infection sites in second position.

#### **Activity 51: PMTCT**

The main activities associated with prevention of mother to child transmission that were carried out during the period focused on:

- 1. Reviewing the tools for data collection in connection with PMTCT and pediatric management.** This activity was carried out with the collaboration of the national AIDS control program (PNLS) and ProVIC. A draft version of the collection tools was developed, pretested and made available for testing in some Kinshasa sites supported by ProVIC. A workshop to finalize and validate these collection tools (PMTCT, HIV pediatric management) is scheduled to take place in the next quarter.
- 2. Evaluations of PMTCT sites in May and June.** This activity took place in Kamina from May 9 to 18; in Kolwezi from May 9 to 15; from May 18 to 23 in Luiza; from May 9 to 16 in Tshumbe; and from May 12 to 14 in Mwene Ditu, with full participation of the PNLs and by ProVIC. The objective was to prepare a status report on the different sites, to identify the current state of implementation of PMTCT in the health training activities of the former AXxes project, and to analyze the impact in the community. The methodologies adopted during the evaluation were to conduct interviews, to do reviews of documents, and to make field visits in order to perform direct observation.

The evaluation enabled IHP to collect and analyze quantitative and qualitative data concerning PMTCT activities managed by the AXxes project and the community, to identify gaps in PMTCT services

currently offered, and to propose intervention strategies to fill these gaps and to identify the partners and the type of intervention, with a view to harmonizing PMTCT activities in the health zone.

The summary results of these evaluations are as follows:

**A. Strengths:**

- The local team is motivated and trained to do its work. It has the proven technical capability of the PNLs team to be able to provide supervision and capacity building in HIV/AIDS control activities in the provinces.
- PMTCT management documents exist in some sites.
- ANC sessions are organized every week.
- Auditory and visual confidentiality is assured in certain sites.
- In some sites, certain minimum services are provided free of charge for persons living with HIV (consultation, some lab tests, etc.).
- At most sites, screening and counseling initiated by the service provider in the delivery room (provider-initiated counseling) is carried out.
- There is a code of confidentiality on the ANC card or sheet, so that service providers can get an idea of the woman's serological status.

**B. Areas where improvement is needed:**

- Integrated mapping of stakeholders and of interventions by various partners in HIV control is only partially achieved in the evaluated provinces.
- There is weak leadership and coordination in the PNLs sites visited.
- There is no integrated plan for HIV/AIDS control by all stakeholders in the provinces.
- There is inadequate data collection in the PMTCT sites related to HIV-positive women, male partners, and the monitoring of infants exposed to HIV.
- ARV treatment is very rarely provided for eligible women who are referred to the PEC ARV sites supported by the Global Fund.
- There is a lack of BCC materials and social mobilization for HIV control in health training activities in health facilities and the communities, according to those who were visited and interviewed.
- There is little assistance from the coordination office in implementing HIV/AIDS control activities in the health zones that were visited.
- The ECZs or the PNLs has not organized regular, formative supervision for HIV/AIDS control in the zones that were visited. This is very likely associated with the problems of supervision fees and the cessation of PMTCT activities in many sites. The services of some components of PMTCT are less developed, particularly pillars I, II and IV.
- The infrastructure not suited for high-quality counseling services in most sites (confidentiality is very questionable under most local conditions).
- Activities have stopped in many PMTCT sites due to a lack of inputs (tests, consumables, etc.).
- Immunologic monitoring suffers from a failure to count CD4s and to prepare a biochemical assessment in most health zones.
- There is low involvement of men in ANC activities CPN (and in PMTCT activities).
- The population has poor knowledge concerning PMTCT activities in health facilities. The persons interviewed were also not aware of the three modes of HIV transmission and of the means for preventing each mode.
- There is a lack of early screening in virtually all sites.

- Many stock-outs of tests and other inputs were reported despite the presence of the partners.
- Personnel have not been retrained on the updated protocol.
- There is irregular procurement of data collection tools.
- There is inadequate supervision at all levels.
- There is virtually no monitoring of the mother-child pair.
- The transfer of women eligible for ARV treatment to the health facilities is not efficient because there are insufficient sites to provide care and treatment due to the stock out of ARVs.
- It is impossible for members of the general population to be screened in the PMTCT sites, on the pretext that the screening tests are reserved exclusively for use in connection with PMTCT.
- The community health workers who are active in raising HIV awareness are untrained.
- Tests of babies at 18 months are organized in very few sites.
- There is no psychosocial monitoring or nutritional support for HIV positive women who are pregnant or breastfeeding.
- Very significant loss of children exposed to HIV at 18 months.
- There is no pediatric HIV management in most health zones.

In regard to these areas for improvement, the following recommendations have been made in order to find related solutions that are appropriate and applicable:

#### **1.1. To the local authorities:**

- Reinforce the commitment and leadership of the Congolese authorities in the efforts to control HIV/AIDS, particularly in scale up of PMTCT, and advocate with the Congolese authorities and USG/PEPFAR to offer their support in the form of ARV medications for treating infected persons.

#### **1.2. To IHP:**

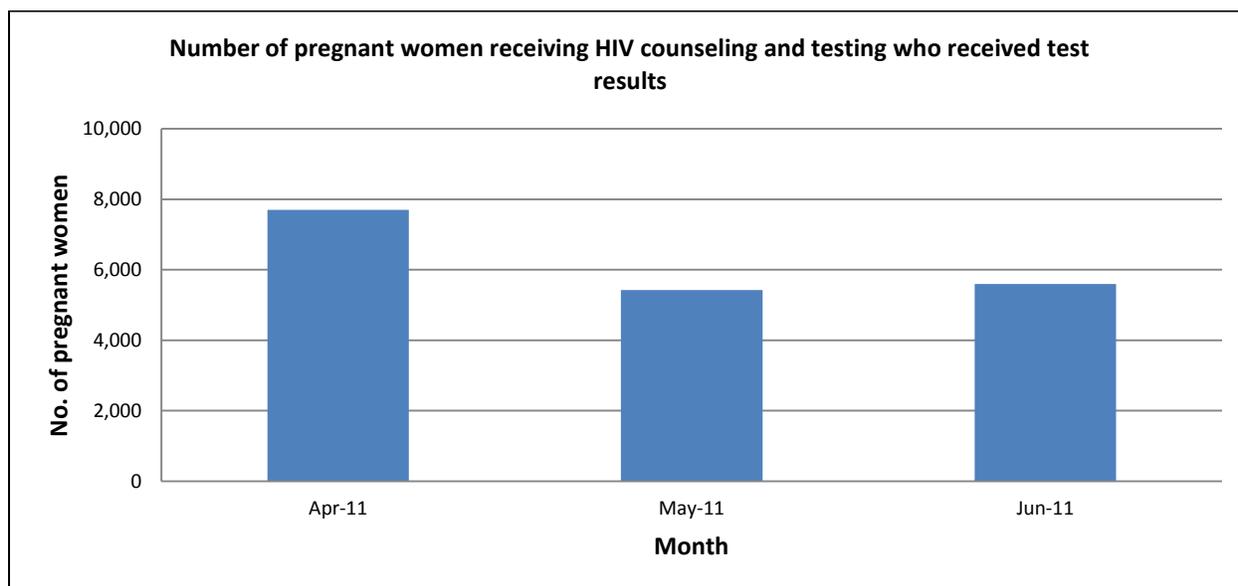
- Expedite ordering of PMTCT inputs in order to make activities in the field effective.
- Scale up PMTCT activities in the provinces.
- Provide nutritional support in the PMTCT sites, in order to improve the nutritional status of people living with HIV.
- Provide the PMTCT sites and the community health workers with awareness raising materials.
- Grant government reinforcement assistance to persons living with HIV in order to offer them financial independence, since most of them live in precarious situations.
- Finalize the MOU with ProVIC with a view to harmonizing activities both nationally and provincially.
- Plan integrated training sessions for service providers in PMTCT sites, for community health workers and for opinion leaders (traditional practitioners, Shirika and Kidjidji leaders, etc.).
- Harmonize HIV/AIDS control interventions with all partners, at both the national and provincial levels, in particular with ProVIC and the Global Fund (Caritas/BDOM), in order to avoid duplication and maximize results.
- Support the activities associated with early screening in the provinces (transportation expenses to Kinshasa).
- Provide the health zones with CD4 counters, spectrophotometers and inputs, for the immunological monitoring of persons living with HIV.
- Support the PNLs and the health zones in putting in place innovative strategies for monitoring the mother-child pair exposed to HIV, and for getting male partners involved.

IHP has sent supplies to the coordination offices of Kolwezi and Kamina to ensure transfusion safety, as indicated in the following table:

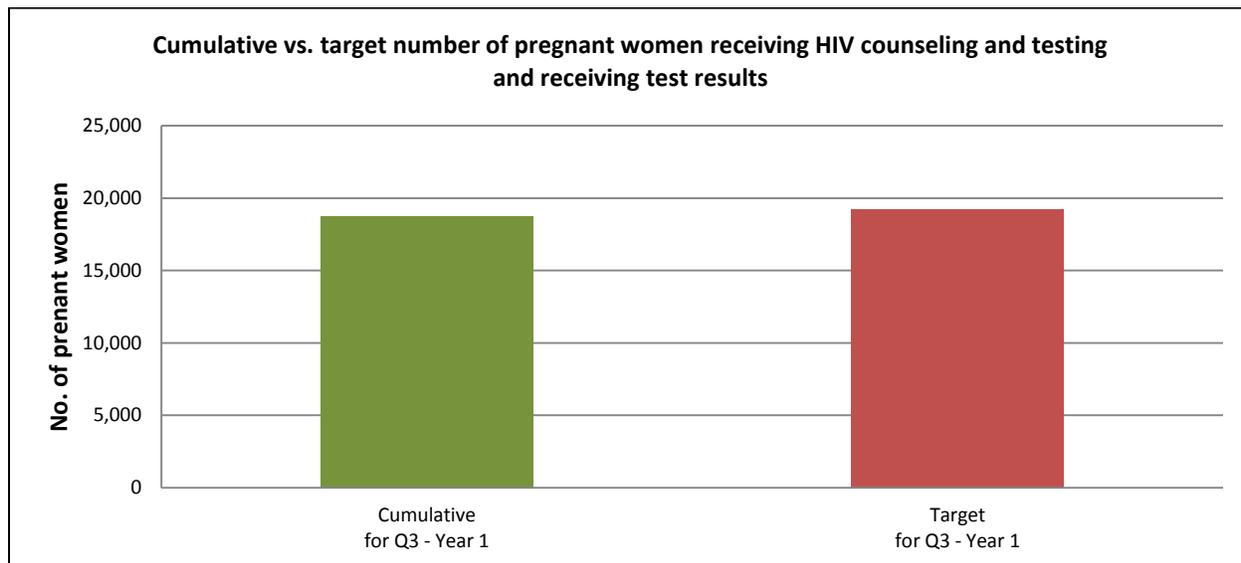
**Table 18: SECUTRANS supplies provided to Kolwezi and Kamina**

SECUTRANS SUPPLIES	Kolwezi coordination office	Kamina coordination office
	• 6000 blood bags	
	• 2500 transfusion kits	• 3500 transfusion kits
	• 30 Determine kits of 100 tests	• 30 Determine kits of 100 tests
	• 50 HCV kits of 50 tests	• 50 HCV kits of 50 tests
	• 10 RPR kits of 100 tests	• 10 PRR kits of 100 tests
	• 30 HB kits of 100 tests	• 30 HB kits of 100 tests

**Figure 23: Number of pregnant women receiving HIV counseling and testing and receiving their test results**



**Figure 24: Actual cumulative vs. target number of pregnant women receiving HIV counseling and testing and receiving their test results**



The number of pregnant women receiving counseling and testing, and receiving their test results, significantly increased from 4,807 in the first quarter to 9,598 in the second quarter and to 18,720 in the third quarter. This can be attributed to the awareness and education campaigns organized by the community health workers, the availability of inputs, and the effort made by the staff of the laboratories to deliver same-day results.

During the next period, IHP will focus its interventions on the full involvement of the national AIDS control program (PNLS) and on collaboration with the ProVIC project. This approach has already proved effective in the evaluation of the PMTCT sites and the updating of the management tools carried out in July with a joint team made up by the PNLS, ProVIC and IHP.

In addition, the transition from monotherapy (Nevirapine) to tritherapy (AZT), advocated by the national policy on AIDS treatment, is an essential activity for IHP, which will be involved in training care providers and in ensuring the availability of necessary inputs, including antiretrovirals, available in all health centers.

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

In April, the fifth directorate of the Ministry of Health organized a workshop on the review and updating of treatment flowcharts in health training activities. The workshop brought together experts from the Ministry's directorates and central programs, and from national and international non-governmental organizations working in the health field. In June, another workshop on development of a guide was organized, with funding from IHP, to brief national trainers on the use of the document. All that is now needed to reproduce the guide is a preface by the supervisory authority (the Ministry of Health).

### ***Activity 2: Design and implement a PBF program***

Activities conducted during this reporting period were essentially based on an internal workshop within IHP, which was held to determine the PBF approach to take. In April, a field visit was made to Mbuji-Mayi and Mwene-Ditu, in order to examine and test how to implement the PBF approach; findings were documented in a status report. PBF indicators were selected, weighted for the health centers, general reference hospitals and health zones, and this was followed in May by selection and identification of the health zones for PBF implementation.

In addition, IHP's PBF Advisor made a field visit to Sud Kivu, to support the local team in selecting health zones that might be able to implement the PBF approach on the basis of pre-established criteria.

In collaboration with colleagues in the IHP coordination offices – more specifically the BCC agents and the specialists in water, hygiene and purification – internal sessions were organized to reflect on the following themes: the key to distribution of bonuses; the system of checking and cross-checking at all levels, in accordance with the advocated pattern and model (intermediate and community); and the use of champion communities in promotional activities.

IHP also participated in three meetings with the Ministry of Health and the partners involved in PBF, including CORDAID. During the period, two workshops were organized by the Directorate of Studies and Planning (DEP) in connection with finalizing and presenting the national orientation document on PBF, and writing the Guide to Operationalizing PBF in the DRC.

This period also saw the design and development of management tools, and drafting of the manual of procedures concerning the IHP PBF model. In the next quarter, these documents will be presented and discussed, both internally and with the partners.

The IHP coordinators and the IHP PBF coordinator met in May to ensure the full understanding of the strategic elements of this component, including the IHP approach and how it will be applied to selected health zones. Bukavu, Uvira and Kolwezi offices, with the assistance of the PBF advisor, participated in the selection of the zones that will adopt PBF in the first phase. Each office selected one health zone, on the basis of criteria including, the accessibility of the health zone, its population, past experience of PBF, insecurity, and its current health indicators. Walungu health zone was selected by the Bukavu coordination office. After the PBF strategy is finalized at the Kinshasa level, field teams will be trained on the concept and finally implementation of PBF will begin.

### **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 3: Extend support for fistula victims***

The stakeholders have agreed to provide financial and technical support to the Kaziba hospital for vesicovaginal fistula repair at the rate of 10 cases per month. This activity will begin in early July under an MOU. IHP has initiated discussions with officials of the Tshikaji hospital in Kasai Occidental, who have promised to send a written proposal to outline the degree of responsibility to be assumed by the two contracting organizations (IHP and IMCK).

In Sud Kivu, IHP selected Kaziba and Panzi hospitals as the medical structures to support with the provision of fistula reparation. These hospitals were selected based on their existing competencies in this treatment. The Uvira coordination office recommended that the Health Zone Management Teams sensitize the community about the availability of fistula repair treatment and direct women with this problem towards IHP to obtain support.

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

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

The team responsible for the KAP survey examined a list of available research reports on which the IHP BCC strategy is based, to set objectives. This includes the MICS 2010, the fistula study of the AXxes Project, and the 2006/2007 study of mortality. It was agreed that the two existing pieces of quantitative and qualitative research will have to be taken into account in strategic planning and in efforts to orient and measure results. The IHP team reviewed the community mobilization activities and the PMP indicators associated with BCC. On the basis of the existing data, current knowledge of the context and the anticipated level of effort required for the various activities, the team worked to finalize the objectives for the process and the results indicators. The IHP baseline survey that is currently under way includes questions concerning knowledge, attitudes and behavior, and will provide information on IHP's strategic approach to BCC. Finally, preparatory work was also done to provide initial orientation in ETL methodology for newly recruited BCC experts and community mobilizers.

#### **IR 3.2 Health advocacy and community mobilization organizations strengthened**

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

By working in collaboration with the representatives of the Ministry of Health and the community development organizations, substantial progress was made in evaluating CODESAs and improving their functioning. The coordination offices were trained in planning activities associated with the revitalization of the CODESAs. The following are some specific achievements:

- Design of tools for collecting data from status reports on the functionality of the CODESAs and on channels and communication, in three coordination offices (Kole, Luiza and Mwene Ditu). The data collection sheets have been developed, and are currently in use in the three coordination offices.
- Finalizing the documents on the organization and functioning of the CODESAs, in order to train health zone managers and community mobilizers in Mwene Ditu. In consultation with the 5th SSP Directorate of the Ministry of Health, some information on the introduction of the champion community approach was incorporated into the training document for participants in the Mwene-Ditu coordination office.
- IHP provided technical support to the training of management team members of 11 health zones (11 community facilitators and 11 supervising nurses) in the Mwene Ditu coordination office on the revitalization and functioning of the CODESAs. The support essentially involved in-depth study and application of the concepts relating to community participation and techniques of communication. Consideration was given to relying on the CODESAs, community coordination units (CACs) and community health worker groups (RECO) for community organization, as these

are community participation bodies. With the support of leaders in the community and of the NGOs/OACs, these bodies, once put in place, can contribute to the adoption of positive behaviors.

- Participation in preparatory meetings organized by the Ministry of Public Health (5th Directorate) for the purpose of planning the workshop to review and validate the manual of procedures for establishing CODESAs and CACs. These meetings resulted in an agreement to revise the manual, which was originally developed in 2003, to integrate such topics as community case management and the community champion approach compromise on revising the manual.

An initial evaluation of CODESAs in health areas was carried out by IHP field teams using an evaluation tool developed by IHP. The evaluation tool included the criteria for functionality that is detailed in documents developed by the Ministry of Health. These criteria are as follows:

1. The CODESA participates in the planning, monitoring and evaluation of the health center's activities.
2. The CODESA co-manages the health center's resources.
3. The CODESA participates in meetings with the health team at the health center.
4. The CODESA organizes work to benefit the community.

The initial results revealed that many CODESAs are barely operational and almost all are at the end of their mandates. There is a clear need to reinvigorate these groups. In the coming reporting period trainings will be held and will be followed by CODESA elections organized in each target health area. The training aims to ensure that CODESA members are clear on their role in ensuring community participation in health activities.

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

#### ***Activity 3: Design and implement health communications campaigns***

In close collaboration with the partners, progress was made in identifying the methodology of the Champion Community approach. A partnership was discussed with ProVIC, to avoid overlapping of activities in the field. The two projects agreed to exchange experiences to achieve better results in the health zones. The initial work of identifying media partners in the provinces has been done, and coordination meetings have been held in Kinshasa with the strategic partners, to develop a comprehensive, integrated communications strategy for the next four years.

Specific achievements include:

- Meetings between ProVic and IHP to harmonize interventions in the field regarding the operation of the Champion Community. To determine the common aspects of intervention between IHP and ProVIC, the community mobilization commission met twice to identify the following points of concordance:
  - For Year 1, IHP plans to put in place eight Champion Communities, one for each coordination office. As a result of these two meetings, the health zones and health areas to be selected according to the logic of joint intervention will be the subject of concerted discussions between the two projects. For the other Champion Communities

- (outside the coordination offices), the two projects will have to develop plans separately, but a collaboration mechanism will be created to share experiences.
- Mapping of the interventions will be undertaken to show the interactions between the different activities supported by ProVIC and by IHP in their common sites.
  - Participation in meetings to harmonize the framework of collaboration between IHP and C-Change. The following decisions have been made:
    - C-Change may have IHP participate in the process of producing communications media. After pretesting and validation of these media by the Ministry, IHP may reproduce them for its own project supported zones.
    - IHP has made comments on the health notebook produced by C-Change.
    - The two parties may exchange working documents.
  - Three advocacy visits were made to the political, administrative and health authorities of Luiza and Mwene Ditu in connection with the introduction of behavior change communication approaches (ETL and Champion Communities).
    - The provincial medical examiner and the development advisor to the governor of the province of Kasai Occidental, and the health district physician of Mwene Ditu, were briefed on the new communication approaches, and were urged to get involved in order to facilitate introduction of these approaches in the health zones.
  - Contribution to the development of PBF indicators, and selection of pilot health zones.
  - Exchanges with PNSR management about reproducing FP awareness media for IHP's 80 health zones. PNSR management plans to solicit IHP's support to reproduce certain awareness media tools (image box, health notebook) to supply the IHP health zones. The next step is for the PNSR to communicate this need in via a letter to the IHP Chief of Party.
  - The exchanges with the MCHIP concerned the inventory of community activities conducted in the sentinel sites. This meeting is the corollary to the activities relating to the PCIME-C.
  - The collection of documentation was made with the national communication program and partners. Communication materials such as posters, brochures, CDs, reports and health notebooks were made available to IHP.
  - Preparatory sessions were held for organizing the training workshop on strategic communication, with a view to organizing BCC campaigns.
  - Regarding the media, 11 journalists from private radio and television chains in Kananga and six journalists from community radio stations were briefed on IHP's objectives and the importance of media in communication to change behavior. This contact has helped to establish a climate of trust to ensure better collaboration in the interests of the population.

## **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***

IHP teams began distribution of Essential General Medicine manuals provided by the Ministry of Health and Tiahrt posters for family planning in all the health zones under Uvira and Bukavu coordination.

#### **I.2A (IR 4): Health sector leadership and governance in target provinces improved**

#### **IR 4.1 Provincial health sector policies and national-level policies aligned**

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

##### ***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 health zone evaluations in Bukavu, Uvira, and Kolwezi revealed that no staff in the health zones were currently using the DHIS despite the training that had been provided to them by the AXes project prior to the launch of IHP. Their continuation of the use of SNIS/GESIS can be explained by the fact that the implementation of the new system had not yet been finalized by the time IHP began. In addition, the majority of health zones do not encrypt data at their level – this is done at the provincial level. IHP will be reinforcing health information activities at all levels in order to combat these deficiencies and is currently participating in developing the strategy for this work in collaboration with the provincial health information division and other partners.

IHP supported two series of SNIS training in the Tshumbe coordination office, for members of the health zone management teams and service providers respectively. In May, training was provided to 32 members of the seven ECZs of the Tshumbe coordination office, including 03 women and 29 men (10 doctors, 08 AGs (health aides?) and 14 nurses). In June, 112 care providers were trained, including three women and 109 men (charge nurses (ITs) and nursing assistants (ITA)).

##### ***Activity 5: Provide the health zones with management tools***

IHP teams delivered several management tools including the SNIS report template to health zones. IHP also placed the order for all other tools currently in use, such as pre-school consultation, prenatal consultation, and consultation files and will supply these to health zones in the coming quarter.

##### ***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 teams are currently providing technical support (supervision and assistance with monthly monitoring meetings) to all health zones (with the exception of Mulungu and Kalehe). During their monthly activity review, IHP is supervising activities and assisting with the management of medicines, family planning commodities, and mosquito nets provided by IHP. Financial support for these activities will be provided once USAID approves the granting mechanism.

## **II. PROJECT MANAGEMENT**

During the second quarter, IHP staff continued start-up activities and participated in a number of key USAID-supported activities.

- **USAID visit to Kolwezi coordination office:** A USAID team visited the Kolwezi coordination office, May 15-19, to review the activities of the IHP coordination office, visit the pharmaceutical warehouse (CADIMEK), and visit the health zones of Fungurume, Lubudi, Lualaba and Manika. The trip provided an opportunity for USAID to identify some of the challenges associated with

IHP start up in Kolwezi and to propose some recommendations and immediate actions to ensure that gains made by the previous AXxes Project are maintained and that IHP is able to achieve its expected results in this region.

- **Baseline survey:** During this quarter, the Integrated Health Project (IHP) completed a baseline survey in the eight coordination offices covering nine areas of supervision. There is one area of supervision for each coordination office except for the Bukavu office, for which there are two. The executive summary of the baseline survey is included as Annex 2.

The general aim of the survey is to establish a benchmark that will enable IHP to reliably assess the interventions that will be made in the course of its implementation. More specifically, the survey had the following aims:

- To collect data for calculating the coverage of the project's indicators at the start of its implementation, in the following sectors: children's health (nutritional status, vaccine coverage, management of childhood illnesses); reproductive health (contraception, antenatal care, deliveries, postnatal care); HIV/AIDS; and water and purification.
- For each supervision area, identify the sectors that are functioning well (high coverage) and those that are not functioning well (weak coverage).
- Identify the high-performance supervision areas from which one can learn.
- Define the priorities among the supervision areas that have great differences in coverage.
- Define the priorities among the sectors in each supervision area.

The survey used Lot Quality Assurance Sampling (LQAS) as a sampling method. Application of this method made it possible to randomly select 25 interview locations per supervision area, or a total 225 interview locations for the entire zone covered by the project. Data collection was carried out from May 3 to June 3, 2011 by 38 survey workers, organized into 19 teams under the direction of four field supervisors. In total, nine questionnaires, corresponding to the nine target groups in the survey, were used to collect the data in the 208 interview locations visited.

The target groups were:

- Children 0-23 months of age
- Children 0-23 months of age with diarrhea
- Children 0-23 months of age with presumed pneumonia
- Children 0-23 months of age with fever
- Children 6-23 months of age
- Children 12-23 months of age
- Children 0-5 months of age
- Pregnant women (15-49 years of age)
- Mothers of children 0-23 months of age.

The information sought on these groups was based on the current knowledge and behaviors of the women/caregivers. The indicators were measured in the following fields:

- Contact with health services
- Children's nutrition
- Vaccine coverage of children 12-23 months of age
- Treatment of illnesses and knowledge of symptoms

- Family planning
- Maternal health
- HIV/AIDS and risky sexual behavior
- Water and purification

The following is a summary of the results obtained in the coordination offices, by field:

1. **Contact with health services:** Analysis of the indicators of contact with health services, by supervision area, shows that the supervision areas with weak performances are: Luiza and Uvira for contact with a health professional; Luiza, Mwene-Ditu and Bukavu 2 for the practices learned through contact with health professionals; and Kamina for the channels for receiving health messages.
2. **Children's nutrition:** Most of the nutrition indicators show disparities in favor of the children in an urban environment and of those whose mothers know how to read and write. By supervision area, weak performances are observed in Tshumbe, Kamina and Bukavu 2 for initial breastfeeding; in Luiza, Kamina and Uvira for exclusive breastfeeding; and in Kole and Kamina for Vitamin A supplementation. In regard to the indicators on the nutritional status of children, the analysis with the LQAS method shows that all the supervision areas have a weak performance.
3. **Health of children:** Vaccine coverage of children is higher in urban environments, and increases with higher literacy on the part of the mother. The health areas that have poor performances in terms of health coverage are: Kamina for the tuberculosis vaccine (BCG); Mwene-Ditu, Kole, Kamina and Uvira for the third dose of polio vaccine (VPO3); Kamina and Uvira for the third DTCoq dose (DTCoq3); Kole and Kamina for the measles vaccine; Kole, Kamina and Uvira for the third dose of Hepatitis B vaccine; and Kole, Kamina and Uvira for the yellow fever vaccine.

The Kamina supervision area has a poor performance in terms of seeking care in the appropriate health services in the case of presumed pneumonia in children. In addition, the supervision areas of Mwene Ditu and Kamina are low performers in the administration of the antibiotics to treat presumed pneumonia.

All the supervision areas perform well in providing adequate management of diarrhea.

The supervision areas with weak performance in malaria prevention are: Mwene-Ditu in regard to the availability and use of MII; and Kole and Uvira regarding the use of MII by pregnant women.

The survey indicates that 26% of children 0-23 months of age that had fever in the two weeks preceding the survey had taken some antimalarial drug to treat the fever, within 24 hours after the fever had appeared. All the supervision areas perform well in this field.

The Luiza supervision area does not perform well in terms of knowledge of the warning signs for childhood illnesses.

4. **Reproductive health:** Knowledge of modern family planning methods is poor in the supervision areas of Kole, Tshumbe, Kamina and Uvira. Coverage of antenatal care is high in the IHP target

zones. Kole and Kamina are the supervision areas that have a poor performance in terms of institutional deliveries.

The practice of postnatal care is also poor. Less than one mother of a child 0-23 months of age out of five (18%) had been examined by qualified medical staff in the three days following the delivery.

5. **HIV/AIDS and sexual behaviors:** Virtually all women 15-49 years of age (96%) have heard of HIV/AIDS. However, only 53% of women know about the two principal means of HIV prevention; 26% reject the two most common mistaken ideas about HIV/AIDS and know that a person who appears to be in good health may have the AIDS virus; and finally, only 17% of women 15-49 years of age have a thorough knowledge of HIV.

The results of the analysis using the LQAS method show that the supervision areas with poor performances are: Kole and Kamina for thorough knowledge of HIV/AIDS transmission; Kamina and Uvira for HIV transmission from mother to child; and Mwene-Ditu, Kole, Tshumbe and Kamina for the HIV screening test and knowledge of one's serological status.

6. **Water and purification:** The analysis of the water and purification sector using the LQAS method shows that the supervision areas of Luiza, Kole, Tshumbe and Kamina have a poor performance in terms of using improved sources of drinking water, while Luiza, Kole and Tshumbe do not perform well in regard to the availability of soap anywhere in the home.

**Table 19: Distribution, by supervision area, of the number of interview locations selected and conducted for the baseline study**

Distribution, by supervision area, of the number of interview locations selected and of the number of interviews conducted			
Order number	Name of supervision area	Number of interview locations selected	Number of interviews conducted
1	Luiza	25	25
2	Mwene-Ditu	25	25
3	Kole	25	25
4	Tshumbe	25	24
5	Kamina	25	25
6	Kolwezi	25	25
7	Bukavu 1	25	19
8	Bukavu 2	25	19
9	Uvira	25	21
<b>Total</b>		<b>225</b>	<b>208</b>

This table above indicates that a total of 208 interviews were conducted and 1,872 questionnaires were completed in the nine supervision areas making up the field of study for this survey. The people conducting the survey in Uvira and Bukavu were directed to do 19 interviews instead of 25 because of the accumulated delays in implementing the survey in these areas, due to lack of security.

- **Communications, Branding and Marking Training (May 30-June 3, 2011, in Kinshasa):**

MSH Director for Communications from the Center for Leadership and Management conducted two, two-day trainings in May/June. The first, for field-based teams, took place Tuesday, May 31 and Wednesday, June 1, 2011, at the Hotel Meriba in Kinshasa. Twenty-two field-based staff participated. The second, for Kinshasa-based staff, took place Thursday and Friday, June 2-3, 2011 at Caritas. Nineteen staff participated, although participation levels varied throughout this training because of prior or competing commitments. The purpose of the communications training was three-fold:

- Share MSH’s theory and practice of project communications, “Thinking & Talking Impact,” with a particular emphasis on the writing success stories that clearly communicate project results and impact. By the end of the training, participants knew how to identify and write a success story that follows a simple format – “challenge-activity-result” – that corresponds to the USAID success story format.
- Review the USAID-approved communications plan and work together to finalize the key messages of the DRC-IHP. By end of training, participants understood the elements and objectives of the DRC-IHP communications plan and contributed to the finalization of the project’s key messages (which will be used in communications moving forward).
- Review the USAID-approved branding and marking plan, and discuss DRC-IHP branding and marking challenges. By end of training, participants understood the rules, regulations and expectations of USAID regarding project branding and marking, as well as their personal responsibility in ensuring compliance with this branding and marking plan.

- **Official Project Launch:**

In June, at the request of the partners, IHP organized an official presentation of the project based on its mission, vision and objectives, its different areas of intervention, and an inventory of the main activities prescribed and defined for the first year. The ceremony enabled those responsible for the project to make direct contact with the local authorities, who used this opportunity to explain the real needs and situation in each region and its respective areas. The Project staff took the time to explain the main features of the Project to the political and administrative authorities and to staff of the Ministry

**Table 20: Dates of IHP project launch presentations**

Supported Provinces	Place of Presentation	Date of Presentation
Kasaï Occidental	Kananga	June 28, 2011
Kasaï Oriental	Mbuji Mayi	May 20, 2011
Katanga	Lubumbashi	June 24, 2011
Sud Kivu	Bukavu	June 28, 2011

- The action plan covering the period from June to September 2011 was approved by USAID.
- Regular monthly meetings with the team of the Secretary General of the Ministry of Health have been organized. At these meetings, Project staff members report on the activities carried out in the field, and discuss any problems that have been encountered.

- **Meetings:**
  - **Malaria Task Force Meeting held on April 5, 2011, in Sud Kivu.** IHP teams participated in a meeting organized by the national malaria program. The national malaria program's communication plan and the results of the joint advocacy mission by UCP/PARSS, UNICEF and PNLN were presented by the program's coordinators. The discussions indicated that IHP could continue to routinely distribute mosquito nets, while other partners will do so during distribution campaigns.
  - **Coordination meeting with local authorities in Bukavu on April 19, 2011.** The IHP team organized this meeting in order to lobby for the authorities' ownership of the LDP program. Government representatives agreed to involve themselves in this program and expressed its usefulness not only for their work in the field of health, but other areas under their responsibility.
  - **Grants Management Meeting in Bukavu on July 7, 2011.** The IHP team held a meeting with all IRC senior management staff in Bukavu to present the project, review the purchase request tracking system, the purchase, spending and recruitment plans, and ensure a solid comprehension of the project objectives and management structure to improve coordination and planning.
  - **Comité Provincial de Pilotage Meeting in Sud Kivu on June 2, 2011.** IHP was among several partners to financially contribute and participate in this meeting organized by the Sud Kivu Provincial Ministry of Health, with the honorary presence of the Provincial Governor, in order to adopt the operational action plan for the province, developed with the assistance of IHP in the previous reporting period. The Provincial Health Minister of Sud Kivu addressed an official letter to IHP to request the transfer of the project's support from Kalehe health zone to Fizi health zone, due to existing support from Great Britain's Department for International Development (DFID) already available in Kalehe. This letter has been transmitted to the IHP coordination in Kinshasa, discussions on this were held with USAID during their visit to Bukavu, and IHP is currently awaiting the response from USAID on this issue.
  - **Coordination meeting in Sud Kivu.** IHP teams participated in this meeting, organized by the NGO Malteser International, aimed at harmonizing the interventions of actors working in the same six health zones in order to avoid overlap and maximize the effectiveness of interventions.
  - **Provincial Medicine Commission Meeting in Sud Kivu on June 10, 2011.** IHP teams participated in and provided technical support during this meeting organized by the Provincial Ministry of Health. The meeting brought together the majority of actors working in the health sector in Sud Kivu in order to harmonize support with pharmaceutical supplies, analyze methods of improving the pharmaceutical sector, and discuss progress on the establishment of a regional distribution center.
  - **Grants Management Meeting in Kolwezi on May 11, 2011.** The IHP team held a meeting with the presence of all IHP staff, IHP Deputy Chief of Party, and IRC grants manager responsible for IHP, to review the purchase request tracking system, the purchase, spending and recruitment plans, and ensure a solid comprehension of the project objectives and management structure to improve coordination and planning.
  - IHP assisted the organization of a review of activities carried out during the first trimester of 2011 with the technical office of Kolwezi health district held in Kolwezi on June 13-14, 2011.

- IHP provided technical and financial assistance to the provincial technical office to review activities carried out in the first trimester of 2011 in Lubumbashi on June 16<sup>th</sup> to 18<sup>th</sup>.
- IHP participated in a coordination meeting of partners working in Kolwezi health district on HIV/AIDS. The meeting was organized by the PNMLS with the objective of mapping partners' interventions and lobbying local government authorities to sensitize them to HIV/AIDS issues.

- **Opening of provincial representation offices:**

IHP provincial representation offices are open in three provinces, to resolve problems of visibility and representation, and to provide technical assistance to the provincial health divisions and health ministries. Two former directors of Luiza, Mwene Ditu, and Bukavu have been appointed as representatives of Kasai Occidental, Kasai Oriental, and Sud Kivu, respectively, and one of the field office supervisors has assumed the duties of provincial representative in Katanga.

### **III. FAMILY PLANNING AND HIV STATUTORY REQUIREMENTS**

As mentioned on page 26, IHP staff distributed 3,280 Tiaht posters in the eight coordination areas.

The course on the Tiaht Amendment was translated into French and sent to all members of the technical staff, both in the national office in Kinshasa and in the coordination offices, but only those in Kinshasa were able to complete the course as required. Six people completed the requirements. During the next reporting period, all technical staff will be required to complete this course, as well as any staff involved in monitoring, commodity security, and compliance.

In addition, all new technical staff members who were in Kinshasa at the time of the orientation were briefed on the requirements of the Tiaht Amendment, and used this opportunity to talk about violations of the regulations in other countries like Egypt, and about the negative consequences if they are not complied with during the implementation of this project.

### **IV. ENVIRONMENTAL MONITORING AND MITIGATION PLAN**

During the next reporting period, we expect USAID's Regional Environmental Compliance Advisor to approve the EMMP. While waiting for this approval, IHP implemented some of the key activities contained in the plan, as follows:

**Medical waste management:**

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

**Training and capacity building**

- The IHP technical advisors team validated 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 training is planned in the other coordination offices for the next quarter.

#### 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.

## V. CHALLENGES ENCOUNTERED

A number of challenges were addressed during this reporting period.

- **Difficulties on collecting health information.** Due to the poor organization of the SNIS in Sud Kivu, IHP teams were unable to obtain the required health information for all of the target health zones. In addition, the SNIS in Sud Kivu produces information on a monthly basis on the 15<sup>th</sup> of each month, which causes difficulties for IHP teams to obtain this information in line with the current IHP deadline of the 10<sup>th</sup>. IHP teams have begun collecting data in the field directly from health zones and proceeded to compile the information for certain health zones. IHP will proceed with an analysis of ways to improve the efficacy of the work of the provincial SNIS and proposes to adjust the internal IHP deadlines to fit the provincial deadline (20<sup>th</sup> of the month) in order to facilitate the timely collection and verification of health information.
- **Contractual issues** continued to prevent the signature of sub-grants with the health zones. The MSH-supported zones are receiving direct support, and MSH has also begun doing the same direct support in the IRC coordination areas. This is problematic since IRC cannot manage the MSH funds in those areas. The MSH Senior Contracts Officer is working to resolve this issue with USAID to quickly get the approvals needed to get the sub-grants in place.
- **Access problems** due to flight cancellations between Shabunda and Bukavu also contributed to delays in reporting health information from Shabunda, Lulingu and Kalole, as IHP staff conducting field visits to collect information in these health zones was unable to leave these sites after having travelled there to collect information for three weeks. IHP is investigating the possibility of a small satellite office in Shabunda in order to alleviate access problems. In addition, IHP has been unable to access Mulungu health zone due to armed group activity in this zone causing population displacements in certain villages. A map indicating this area can be found in Annex 8.

- The security situation in the health zones in Uvira remains fragile, with the presence of armed groups in several areas, particularly Haut-Plateau.
- IHP had difficulty communicating with Haut-Plateau because of insecurity (as above) as well as the lack of a mobile phone network in the area. CODAN radios can be used, but this is not ideal with armed groups operating in the area. IHP is exploring the possibility of providing this health zone with a satellite phone to improve communication with the health zone.
- A shortage of computers and cameras, which are currently being procured, was an additional obstacle for IHP teams to work with.
- Regarding the PBF approach:
  - Due to the low level of knowledge of those responsible for PBF in the Ministry of Health, the partners tend to act in this area, and the Ministry does not know how to fully play its normative and regulating role in implementing PBF at the national level. Although IHP is not directly involved in the activities planned for the project, given the importance of the role of the Ministry of Health, it does provide technical support for the national PBF cell in order to build its capacities, as the report indicates. IHP will continue to do this.
  - There are several PBF approaches and partners in the country, which result in strategic positioning conflicts. Given the great experience of MSH in PBF, the innovative approach of IHP which insists on quality and capitalizes on such tools as FOSACOF and LDP, and also the weight of USAID in the DRC through IHP, the project expects to play a leadership role in implementing PBF at the national level.
  - Internally, many of IHP's technical managers are not familiar with PBF. Some have been directly or indirectly in contact with PBF. Lack of knowledge about PBF, or of the difference between how IHP has set up PBF and some of the known approaches to PBF, have somewhat slowed progress as staff need to understand the approach. This is a typical start-up phase for PBF and is being addressed through training. IHP's PBF manual of procedure has been written, and the information sessions and training that will be organized will help staff, both at the national level and in the coordination offices, to have the same approach and thereby ensure efficient implementation of PBF.
  - As the PBF program has not yet begun, staff in the coordination offices have not been fully sensitized to the upcoming activities and do not currently feel directly responsible for PBF. IHP will recruit for positions in the coordination offices in the next reporting period whose scope will be to monitor PBF activities and respond to the demanding implementation requirements of these activities: prompt response, complete information and transparency, and provision of high quality data. With the completion of the PBF procedures manual, the roles and responsibilities of the different actors will be clearly defined over the next quarter. The IHP Management Team will play a key role in this process.

## **VI. PLANNED ACTIVITIES FOR NEXT QUARTER (JULY-SEPTEMBER 2011)**

For an overview of activities for the next quarter, please see the attached approved workplan for the period June-September 2011 (Annex 4). Some highlights of selected activities are included below.

**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):

- Finalize the evaluation of MPA and CPA availability in Sud Kivu in collaboration with the Provincial Health Division.
- Continue distribution of medical supplies (medicines, mosquito nets, family planning items).
- Continue support to health zones, in particular with facility supervision visits.
- Identify six health facilities for rehabilitation in six health zones in Kolwezi, in partnership with the provincial health management team and local authorities.
- Carry out the Leadership Development Program in Kolwezi.
- **Malaria**
  - Provide technical, logistical and financial support to health zones during ITNs campaign in Katanga and the two Kasai.
  - Continue to finalize and implement distribution plan for delivering all commodities (nets, ACTs, and RDTs)
  - Complete the update of situational analysis of malaria commodities distribution (ACTs, RDTs and ITNs) in targeted health zones

**Component 1, IR 2 (Quality of MPA/CPA-plus services in target health zones increased):**

- Conduct training on clinical flow charts, FOSACOF, BENEFITING management, training of trainers on WASH in Sud Kivu.
- Participate in the training of trainers on the Kangaroo method of childcare for mothers with underweight infants and on communication strategies in Sud Kivu.
- Commence the Clean Villages Initiative in selected villages in Sud Kivu.
- Conduct sanitation activities in two target villages in Kolwezi with the installation of water points and construction of latrines.
- Install 300 water points in the health facilities in Kolwezi.
- Distribute management tools and blood transfusion security items to health facilities in Kolwezi.
- Performance-based financing:
  - Validation of PBF manuals and management tools
  - Training of trainers in PBF
  - Training activities in PBF for service providers
  - Finalize the community indicators
  - Identify the community associations
  - Finalize the process of determining the targets for PBF
  - Write the operational research protocol for PBF
  - Organize meetings with the partners to share the IHP PBF model
  - Develop performance contracts
  - Support the development of the workplans of the structures
  - Sign the performance contracts
- **Water and Sanitation**
  - Train WASH management committees in 20 communities (villages)
  - Contribute to implementation of the Clean Village program in 20 communities (village)
  - Train 60 trainers in the WASH social mobilization strategy (in Bukavu, Kananga and Lubumbashi)
  - Train at least 400 facilitators/community health workers in the community strategy for implementing WASH activities
  - Train 60 trainers (in Bukavu, Kananga, and Lubumbashi) on IHP's WASH technologies

- Build at least 100 water supply points in communities in the IHP health zones, and 2,500 improved latrines
- Equip at least 20 health facilities with the Minimum WASH Package
- **HIV/AIDS**
  - Organize workshop to finalize and validate the PMTCT collection tools, in collaboration with ProVIC and the PNLs.
  - Implement next steps for finalizing the evaluation of the PMTCT sites are as follows:
    - Finalize the evaluation of the PMTCT sites of Sud Kivu
    - Collect the information from the questionnaires
    - Enter the quantitative and qualitative data
    - Analyze the data
    - Write the report
    - Disseminate the resultants
- **Tuberculosis**
  - A program to build the capacities of the community health workers and the friends of Damien clubs is planned as a priority for the health zones where detection is low (particularly in Sud Kivu).
  - A supervision plan for the CPLTs and Health Zones will be implemented in the period from July to September, to identify the efforts already made and the gaps that need to be filled.
  - IHP will 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.
- **Nutrition**
  - Develop the nutrition workplan and database
  - Support organization of the activities of World Breastfeeding Week, scheduled for August
  - Support finalizing of the health notebook for PSC
  - Organize meetings to develop tools for collecting data on Essential Nutrition Actions at the community level
  - Place orders for: nutrition inputs (vitamin A, Plumpy Nut, F100 and 75 Milk) as well as anthropometric materials (scales, height rod, MUAC/cuff)

For World Breastfeeding Week, all IHP coordination offices are submitting to the Kinshasa office the terms of reference for proposed activities. The order for inputs and materials will be placed at that time, in anticipation of implementing therapeutic management of cases of malnutrition and of integrating essential actions in the community, at the start of the second year of the project.

- **Malaria**
  - Integrate complete prenatal counseling into all activities related to maternal, infant, and neonatal health including distribution of IPT and LLINs
  - Continue to distribute ACT and RDT to all health facilities covered by the project; integrate distribution of ACTs and RDTs into other ongoing activities
  - Train health care providers and ECZ members on rapid test in selected health centers that received RDTs in Luiza, Kolwezi, Uvira and Bukavu.

**Component 1, IR 3** (Knowledge, attitudes, and practices (KAP) to support health-seeking behaviors increased in target health zones):

- **Malaria**
  - Analyze preliminary results of the IHP KAP assessment in targeted health zones especially KAP on malaria

**Component 2, IR 4** (Health sector leadership and governance in target provinces improved):

- **Malaria**
  - Complete an inventory with the MOH of all of the existing health policy documents, including norms, standards, and policies for specialized programs
  - Support the Malaria Program Review process with WHO, NMCP/MOH and USAID-PMI
  - Support the NMCP/MOH to develop and/or finalize policy documents (strategic and operational), norms, and strategies including the meeting per province level to discuss about IHP workplan

**Component 1, IR 3** (Knowledge, attitudes, and practices (KAP) to support health-seeking behaviors increased in target health zones):

- Finalize the evaluations of CODESAs in Sud Kivu
- Launch the evaluation and revitalization of CODESAs in Kolwezi
- Analyze the results of the IHP baseline survey
- Carry out the evaluation of the media

**Component 2, IR 4** (Health sector leadership and governance in target provinces improved):

- Ensure financial and technical support for health zone supervisions and monthly monitoring meetings
- Organize LDP workshops in Kolwezi

## **VII. SUCCESS STORIES**

The DRC-IHP Success Stories appear on the following pages.

## VIII. ANNEXES

1. IHP Health Indicators Q3 Y1
2. IHP Baseline Study Report – Executive Summary
3. IHP PMP
4. Approved Quarterly Workplan for June – September 2011
5. Analysis of Vaccination Data
6. Summary of Results of the FOSACOF Evaluation
7. Evaluation of Community Health Sites – South Kivu
8. Map of HZ Affected by Insecurity (attached as PDF)
9. Updated AXxes Inventory – Kolwezi (attached as Excel)
10. Updated AXxes Inventory – Bukavu (attached as Excel)
11. Updated AXxes Inventory – Uvira (attached as Excel)
12. Cold Chain Supplies Plan – South Kivu (attached as Excel)
13. Mosquito Net and FP Distributions – South Kivu (attached as Excel)
14. Villages Selected for Clean Villages Approach – South Kivu (attached as Excel)
15. IHP Organization Chart (attached as PDF)
16. International STTA Plan (attached as PDF)
17. IHP Accruals Report April - June 2011 (attached as PDF)
18. IHP SF425 June – April 2011 (attached as PDF)

## ANNEX 1: IHP HEALTH INDICATORS PROJECT YEAR 1 QUARTER 3: APRIL – JUNE 2011

<b>IHP HEALTH INDICATORS PROJECT YEAR 1 QUARTER 3: APRIL - JUNE 2011</b>						
<p>IHP received data from 1,467 health facilities for the months of April and May while 1,477 health facilities sent data for June. Data from Buniakiri (Bukavu) was unavailable for the month of April while data from Mulungu, Kalole and Lulingu was unavailable for the month of May. The team was not able to reach these areas due to the presence of soldiers affiliated with the FDLR (Democratic Forces for the Liberation of Rwanda) which heightened security risks. The security situation in Mulungu continued in June making it impossible to travel there to collect information. At the same time, an issue with GESIS made it difficult to obtain data from Fungurume (Kolwezi).</p>						
<b>INDICATORS</b>	<b>Apr-11</b>	<b>May-11</b>	<b>June-11</b>	<b>Q3Y1</b>	<b>Target for the quarter (cfr PMP)</b>	<b>Achievement (%)</b>
<b>FAMILY PLANNING</b>						
1. Couple years of protection (CYP) for FP USG-supported programs	36,493	40,439	39,520	116,453	79,714	146
1a. Couple years of protection (CYP) after exclusion of MAMA and MAO for FP USG-supported programs *	15,143	13,915	14,364	43,423	No target in the PMP	
2. Number of new FP Acceptors in USG supported family planning clinics	6,276	6,825	7,071	20,172	93,769	22
2a. Number of new FP Acceptors of modern method in USG supported family planning clinics	38,410	44,814	47,509	130,733	No target in the PMP	
3. Number of counseling visits for FP/RH as result of USG assistance	22,831	26,497	27,016	76,344	No target in the PMP	
4. Number of USG-assisted services delivery points providing FP counseling or services	1,466	1,466	1,477	1,477	1423	104
<p><b>Comments:</b> The number of counseling visits increased from 42,313 last quarter to 76,344 this quarter. This is due in part to the motivation of community-based distribution (CBD) workers who received bicycles and who increased the number of home visits and number of performance days per week (NB: Although the bicycles arrived late in the reporting period, simply knowing they were getting them motivated the CBD workers to launch a competition that resulted in increased home visits and community mobilization activities). All modern method acceptors had a combined increase of 30.4% (Q2: 100,213 and Q3: 130,733) though the number of new acceptors of modern clinical FP methods (requiring the presence of a provider) decreased by 38% compared to last quarter (Q2: 32,477 and Q3: 20,172). This is due to the fact that more acceptors during this period adopted and used methods of self-observation, Lactational Amenorrhea Method, cycle beads and condoms. During this current reporting period, only 15.4% of the total number of acceptors (20,172/130,733) adopted LAMP compared to the previous quarter's reported 32.4% (32,477/100,213).</p>						
<b>INDICATORS</b>	<b>Apr-11</b>	<b>May-11</b>	<b>June-11</b>	<b>Q3Y1</b>	<b>Target for the quarter (cfr PMP)</b>	<b>Achievement (%)</b>
<b>MATERNAL AND CHILD HEALTH</b>						
1. Number of antenatal care (ANC) visits by skilled providers from USG-assisted facilities	39,406	41,183	39,612	120,201	111,556	108
2. Number of deliveries with a skilled birth attendant (SBA) in USG- assisted programs	32,044	34,682	32,455	99,181	91,279	109

3. Number of women benefiting from Active Management of the Third Stage of Labor(AMTSL) through USG-supported programs	23,638	27,674	25,540	76,852	69,266	111
4. Number of postpartum newborn visits within 3 days of birth in USG-assisted programs	28,368	30,969	29,068	88,405	87,005	102
5. Number of newborns receiving essential newborn care through USG-supported programs	27,234	30,010	28,517	85,761	84,114	102
6. Number of newborns receiving antibiotic treatment for infection from appropriate health workers through USG-supported programs	4,253	5,681	6,092	16,026	3,741	428
7. Number cases of child pneumonia treated with antibiotics by trained facility or community health workers in USG-supported programs.	32,318	29,216	27,863	89,397	112,920	79
8. Number of cases of child diarrhea treated in USAID-assisted programs	19,774	41,189	23,727	84,690	76,827	110
9. Number of children less than 12 months of age who received DPTHB3 from USG-supported programs	36,944	33,961	33,356	104,261	86,065	121
10. Drop out rate in DPTHB3	4.1	4.2	5.1	4	No target in the PMP	
11. Number of children less than 12 months of age who received vaccine for measles	32,796	32,561	28,586	93,943	No target in the PMP	
12. Number of children under 5 years of age who received vitamin A from USG-supported programs*	11,090	1,405,578	0	1,416,668	1,153,234	123
13. Number of pregnant women received VAT 2+ from USG- supported programs	35,649	38,400	33,689	107,738	No target in the PMP	
14. Rate of use of health services *	38.3	38.8	39.7	38	No target in the PMP	
<p><b>Comments:</b> There was a slight decrease in the number of prenatal consultations attributed to health zones that organized vaccination campaigns against measles in the province of Eastern Kasai specifically in the health districts of Mbuji Mayi and Mwene Ditu. During the campaign, health facilities were closed as head nurses left to conduct outreach activities in surrounding villages. However, the rate of curative services increased from 32% to 39% due to availability of drugs and ITNs, and improved quality of service provided by skilled providers in health facilities. Furthermore, education campaigns and community mobilization followed by home visits were strengthened by highly-motivated CBD. After starting the revitalization of CODESA, several committees were revived and expressed renewed commitment towards serving as a bridge between the community and health centers. There was a decrease in June in the number of children under 12 months who received DPTCHepBHib3 compared to the numbers in April because:</p> <ol style="list-style-type: none"> <li>1. The result obtained in April (36,944) is due to the recovery of unvaccinated children in IHP-targeted health areas following vaccine stock-outs in March.</li> <li>2. The result for June (33,356) is slightly below the monthly target population because data from the health areas of Fungurume (Kolwezi) and Mulungu (South Kivu) were not obtained.</li> </ol> <p>Finally, in May, there was a vitamin A distribution campaign during which 1,405,578 children under 5 received vitamin A.</p>						
<b>INDICATORS</b>	<b>Apr-11</b>	<b>May-11</b>	<b>June-11</b>	<b>Q3Y1</b>	<b>Target for the quarter (cfr PMP)</b>	<b>Achievement (%)</b>
<b>MALARIA</b>						
1. Number of Insecticide-treated nets distributed that were purchased or subsidized with USG support	33421	51817	103174	188,412	200,000	94

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	0	No target in the PMP	
3. Number of USG-assisted services delivery points experiencing stock-outs of specific tracer drugs: ASAQ ( Artesunate+ Amodiaquine) 50 mg (1 - 5 years)	25	44	32	34	6%	2
3 a. Number of USG-assisted services delivery points experiencing stock-outs of specific tracer drugs : ASAQ (Artesunate+ Amodiaquine) 25 mg (< 1 an)	46	54	32	44	6%	3
4.* Number of artemisinin-based combination treatments (ACTs > 13 years) purchased with USG-support	33889	40865	31176	105,930	No target in the PMP	
4** Number of artemisinin-based combination treatments (ACTs 6 - 13 years) purchased with USG-support	24011	34381	21739	80,131	No target in the PMP	
4***. Number of artemisinin-based combination treatments (ACTs 1 - 5 years) purchased with USG-support	22010	29976	24783	76,769	No target in the PMP	
4****Number of artemisinin-based combination treatments (ACTs < 1 an ) purchased with USG-support	6748	18172	13382	38,302	No target in the PMP	
5. Number of children under five with malaria treated correctly following the national protocol**	71442	79889	71102	222,433	No target in the PMP	
6. Percent of pregnant women in target health zones who received IPT	49.19	55.24	52.22	52	77,148	
7.Number of pregnant women with malaria treated correctly following national protocol	8870	10313	9156	28,339	No target in the PMP	

**Comments:** Malaria policies and legislation were not adopted during this quarter.

IHP is reporting on quantities of ACT distributed during the quarter. There are no new USAID-supported stocks, but IHP continued to distribute those received in April.

The number of women receiving AMTSL increased from 51.158% (Q2) to 76.852% (Q3). On average, 52% of pregnant women who go to prenatal consultations receive a dose of Sulfadoxine-Pyrimethamine (SP), the intermittent preventive treatment of malaria for pregnant women (IPTp) under national policy (52%). It is worth noting that, unfortunately, several health zones in Kamina, Kolwezi, Uvira and Bukavu had stock-outs of SP. The percentage of pregnant women in target health zones who received IPT decreased slightly from last quarter, from 55% down to 52%.

INDICATORS	Apr-11	May-11	June-11	Q3Y1	Target for the quarter (cfr PMP)	Achievement (%)
<b>TUBERCULOSIS</b>						
1. Case notification rate in new sputum smear positive pulmonary TB cases in USG-supported areas	970	1062	1213	3,245	4,407	74
1a. Case notification rate in new sputum smear positive pulmonary TB cases in USG-supported areas without HZs with high detection rate	90	42	266	398	No target in the PMP	
2. Percentage of all registered TB patients who are tested for HIV through USG-supported programs	33	61	55	50	50	99
3. Percent of the estimated number of new smear-positive pulmonary TB cases that were detected under DOTS ( i.e. case	74	81	88	81	85	95

detection rate)						
4. Percent of sputum smear positive pulmonary TB patients that were cured and completed treatment under USG-funded DOTS.	33.2	52.2	55.1	47	No target in the PMP	
5. Treatment success rate in USG-assisted DOTS Plus programs to treat MDR TB patients	0	0	0	0	55	0

**Comments:** The rate of recovery remains low (33.2%, 52.2% and 55.1% in April, May and June respectively) due to RHEZ stock-outs, insufficient number of health centers for diagnosis and treatment (CSDT) and health centers for treatment (CST), and poor implementation of community DOTS in most health zones. A plan to extend CSDT and CST is expected during the next quarter with various provincial coordinations in the fight against TB (CPLT) and site assessment is planned notably in South Kivu (where detection rate is weak) and Kamina (with detection rate higher than 100 in six health zones). A plan with CPLT to implement community DOTS strategies in certain HZ. An expansion plan for Co infection HIV/TB sites is planned for PY2.

INDICATORS	Apr-11	May-11	June-11	Q3Y1	Target for the quarter (cfr PMP)	Achievement (%)
<b>PMTCT</b>						
1.Number of Pregnant women seen for ANC in PMTCT facilities *	19,622	15,614	20,081	55,317	24052	230
2.Number of pregnant women receiving HIV counseling ***	11,800	10,191	11,223	33,214	24052	138
3.Number of pregnant women receiving HIV counseling and testing ***	7,845	5,434	5,849	19,128	19242	99
4.Number of pregnant women receiving HIV counseling and testing; and receiving test results*	7,699	5,428	5,593	18,720	19242	97
5.Number of pregnant women who tested positive*	56	37	35	128	308	42
6.Number of pregnant women tested HIV positive who receive test result*	55	33	35	123	302	41
7.Number of PMTCT health facilities offering PMTCT services*	138	138	138	138	137	101
8.Number of pregnant women provided with a complete course of antiretroviral prophylaxis for PMTCT*	36	30	32	98	246	40
9.Number of newborns who received a complete course of antiretroviral prophylaxis* **	20	14	18	52	293	18
10.Number of partners/husbands of pregnant women who receive HIV counseling and testing and receive results*	1,952	795	703	3,450	3878	89
11.Number of women receiving CTX and MVI post counseling*	20	63	54	137	308	45
12.Number of newborns receiving CTX and MVI *	6	21	18	45	293	15

**Comments:** Because a number of PMTCT sites have experienced stock-outs of materials such as testing kits, women are not benefiting from screening. Supplies have been ordered urgently and have begun arriving. The withdrawal rate may decrease through efforts by community health workers to encourage women to come obtain their results. Health facilities also motivate women by producing results on the same day. For the next quarter, training on screening is planned for nurses. 52 HIV+ women have benefited from Nevirapine during labor and 46 women received HIV prophylaxis combination, AZT, recommended by 28 SA (old policy). It should be noted that among pregnant women who tested HIV+, five women did not return to obtain their results. They could no longer be tracked due to changes of address. The number of partners/ spouses of pregnant women who received counseling, agreed to be tested and received results have decreased from 1,952 to 703 due to the delay in delivering results. These delays differ from health center to health center, but some of the reasons reported include the heavy workload of the staff (with just one or two lab staff for the general hospital) and the time that it takes to have the supervisor check and approve the test results.

INDICATORS	Apr-11	May-11	June-11	Q3Y1	Target for the quarter (cfr PMP)	Achievement (%)
<b>WATER AND SANITATION</b>						
Number of people in target areas with access to improved drinking water supply as a result of USG Assistance* ( Cumulative during the year)					65595	
Number of people in target areas with access to improved sanitation facilities as a result of USG assistance*			500		31196	
Liters of drinking water disinfected with USG-supported point-of-use treatment products	NA	NA	NA			
<b>Comments:</b> After 20 technicians per province were trained this quarter, construction and rehabilitation of water sources will start next quarter. 1,000 water points are already present in 1,000 health facilities. Latrine rehabilitation was completed in six cubicles at the General Referral Hospital of Miti Murhesha and eight cubicles at the General Referral Hospital of Bagira (Bukavu).						

## ANNEX 2: IHP BASELINE STUDY REPORT – EXECUTIVE SUMMARY

This report documents a comprehensive baseline study on knowledge, practices and coverage of key health areas as part of the USAID-funded Integrated Health Project (IHP in English, PROSANI in French) implemented in the Democratic Republic of Congo (DRC). IHP is a five-year project that supports the National Health Development Program (PNDS) in 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 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/AIDS; and water, sanitation and hygiene in the target health zones.

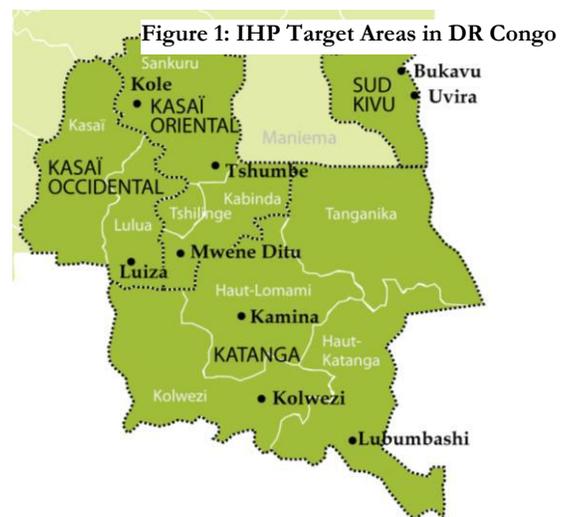
Component 1 supports the first strategic focus of the DRC's national health plan: health zone strengthening. Activities under Component 1 strengthen health zones' capacity to deliver services by addressing both the supply and demand sides of services. Under Component 1, there are three Intermediate Results (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 Intermediate Result is found under component 2:

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

IHP 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.).



## **Baseline Study Objective**

The primary objective of the baseline study is to establish a point of reference through which change will be measured across key IHP performance indicators in subsequent years. MSH and its partners conducted this study as one of three major assessments that are part of IHP's evaluation strategy to assess project effectiveness. The study used a cross-sectional population-based survey to assess the health conditions of young children, their mothers, and women of reproductive age living in IHP target areas.

The baseline findings will contribute to a better understanding of determinants of health for MSH, its partners and other key stakeholders in DRC, including the Ministry of Health (MOH) and other USAID implementing partners that are also implementing interventions and strategies for improving the health of the Congolese people.

## **Study Methodology**

The survey used the Lot Quality Assurance Sampling (LQAS) methodology, a cost-effective yet robust approach to obtain data from a representative sample of communities and households located in the 80 target health zones of the project. IHP administered the survey across nine "lots" or Supervision Areas, primarily management units that IHP uses for project management and implementation of activities. As such, the Supervision Areas reflect almost the same IHP implementation structure of the eight coordination offices located in the project target areas: Luiza, Mwene Ditu, Kamina, Tshumbe, Kole, Kolwezi, Bukavu, and Uvira. However, given the high-population density in South Kivu and the greater number of health zones (23) covered in Bukavu as compared to other IHP coordination offices, Bukavu was surveyed through two Supervision Areas while each of the other seven IHP coordination offices was surveyed through one Supervision Area.

The LQAS sampling framework included a random selection of approximately 25 places of interviews in each Supervision Area, for a total of 208 sites surveyed for the entire area covered by the project. From May 3 to June 3, 2011, 36 trained interviewers, organized into 18 teams led by four field supervisors with significant experience in conducting population-based surveys in DRC, collected data. The entire survey team was managed by a locally-hired Congolese statistician with extensive experience in designing and conducting population-based surveys in DRC.

The survey targeted three major groups: children aged 0-23 months, their mothers, and women of reproductive age. The main rationale for focusing the survey on children aged 0-23 months is twofold: (1) focusing on health characteristics and practices for this population group and their mothers represents the greatest opportunity to improve their health; and (2) adding a wider population group (i.e., 0-59 months) would have significantly increased the resources required to complete survey data collection.

In order to collect survey data for the three major target groups and in all IHP health areas of interest in a cost-effective way, the LQAS baseline survey used a parallel sampling strategy. This strategy used a total of nine survey questionnaires to assess knowledge, practices, and coverage of key health areas in maternal, newborn and child health (MNCH), family planning/reproductive health (FP/RH), HIV/AIDS, nutrition, malaria, and water and sanitation (WATSAN). Tuberculosis (TB) data were not captured by the survey since service statistics on IHP TB indicators obtained from health facilities data sources are more appropriate than those collected from population-based sources.

The use of the LQAS methodology for conducting the survey served two purposes: (1) to obtain an overall picture of health status for the entire project area; and (2) to assess how each Supervision Area is performing in various health areas (MNCH, FP/RH, HIV/AIDS, nutrition, malaria, and WATSAN) according to key performance indicators. While the first purpose will help the project to establish a reference point against which change will be measured for the entire project area, the second purpose will greatly help IHP managers to prioritize health areas that are underperforming or that will need to increase performance in order to achieve end-of-project targets. This will help guide optimal use of project resources for achieving anticipated results and targets as articulated in the project results framework and the performance monitoring plan.

### **Characteristics of Surveyed Households**

The majority of mothers of children 0-23 months interviewed live in rural areas (80%), are married or living with a man (84%), and nearly half of them (46%) do not read or write. The survey also revealed a very young population living in the IHP target area: 30% are under five years of age, more than half (57%) are under 15 years of age, and more than three in five (61%) household members are under 18 years of age. Overall, the average household size is 6.5 people. Sex distribution among children aged 0-23 months was equal.

### **Contact with Health Services**

Overall, 58% of surveyed mothers of children 0-23 months had at least one contact with a health care provider during the month preceding the survey, while 39% have had no contact with health services during the same period. Among those mothers who had contact with health professionals, 45% of mothers learned at least two health practices related to MNCH, FP/RH, nutrition, malaria, or HIV/AIDS.

The survey also revealed the various sources of information mothers use to obtain health and nutrition information for their families. The majority of mothers (89%) use formal networks, including nurses, doctors, midwives and community health workers. At the same time, 39% of all surveyed mothers use informal networks, including spouses, other relatives, friends and neighbors.

As for the channels of health information actively used in the project target area, survey findings showed that mothers use predominantly two channels for receiving health messages: 58% from health workers and 22% from mass media.

Overall, the analysis revealed that the Supervision Areas are underperforming on indicators related to contact with health services: Luiza and Uvira registered low contacts with health care professionals; Luiza, Mwene Ditu and Bukavu-2 learned fewer health practices during contacts with health professionals than in other areas; and Kamina registered the lowest use of information channels for receiving health messages.

### **Child Nutrition**

The survey revealed important information from mothers about essential practices that are critical for childhood health status and development: breastfeeding practices among newborns, food intake, and vitamin A supplementation for infants and young children. The survey also included anthropometric measurements – height and weight – to assess the current nutritional status of young children in the project target area.

More than half (52%) of children 0-23 months were breastfed within one hour after birth, and almost the same proportion (54%) of children 0-5 months were exclusively breastfed. However, ongoing intake of foods was significantly lower than breastfeeding practices: less than a quarter of children (23%) aged 6-23 months were adequately fed with solid, semi-solid or soft foods during the 24 hours preceding the survey. More than three-quarters (76%) of children aged 6-23 months received one dose of vitamin A during the six months preceding the survey.

Malnutrition levels are relatively high among children 0-23 months: 14% of children are underweight (weight-for-age) with 5% severely underweight; 31% suffer from growth retardation (height-for-age) with 18% as severe, and 9% of children have wasting (weight-for-height), of which 5% are severe.

Most of the child nutrition indicators obtained through the survey presented disparities by geographic location of households (urban vs. rural), and according to mothers' literacy levels. Child nutrition is better in urban areas and increases with the degree of literacy of the mother. By Supervision Area, Tshumbe, Kamina and Bukavu registered low performance in breastfeeding practices; Luiza, Kamina and Uvira were low performers in exclusive breastfeeding among children under six months of age; and Kamina and Kole had low performance in vitamin A supplementation. LQAS analyses show almost all areas are underperforming on indicators measuring the nutritional status of young children, particularly for underweight and growth retardation indicators.

## **Child Health**

Among children 12-23 months, 28% received all vaccinations recommended by the Expanded Program of Immunization (EPI), and 6% have not received any vaccinations. Immunization coverage of young children is higher in urban areas and increases with the degree of literacy of the mother. However, these figures should be carefully interpreted as there was a high proportion of survey mothers (67.8%) who reported information about their child vaccination status based on recollection and not through the child vaccination card.

For 56% of children with suspected pneumonia during the two weeks preceding the survey, care was sought from an appropriate health service. Among children with suspected pneumonia, 62% received antibiotics.

Among children aged 0-23 months who had diarrhea during the two weeks preceding the survey, less than one-third (29%) received oral rehydration therapy (oral rehydration salts or recommended home fluids, or increased liquids) with continued feeding.

In the prevention of malaria, the survey revealed that 47% of mothers of children 0-23 months live in households with at least one insecticide-treated net (ITN). In households with at least one net, 47% of children and 33% of pregnant women slept under an ITN the night before the survey.

The survey also found that 26% of children 0-23 months who had fever during the two weeks preceding the survey took an anti-malarial treatment for fever within 24 hours following the onset of fever. Less than half of mothers of children 0-23 months (44%) know at least one symptom of childhood diseases that would trigger them to take the child immediately to a health facility, and very few mothers (8%) are aware of two danger signs of pneumonia.

While the LQAS analysis by Supervision Area showed a mixed set of low performing indicators for various immunization coverage and child health disease rates, Mwene Ditu and Kamina registered the lowest performance for care and treatment of childhood pneumonia, malaria prevention, and use of ITNs in the household.

### **Family Planning and Maternal Health**

Among women aged 15-49 years, 83% know at least one modern family planning method, but only 8% of women currently use a modern contraceptive method. Thirteen percent of women have had a discussion on birth spacing with a spouse/partner. Knowledge of modern methods of family planning is weak in Kole, Tshumbe, Kamina and Uvira.

Less than half (43%) of mothers of children 0-23 months received at least four antenatal care visits by a skilled provider during the pregnancy of the youngest child. Coverage for antenatal care is higher among women who have had contact with a health professional and among those who can read and write.

Less than half (47%) of mothers of children 0-23 months received at least two doses of tetanus toxoid (TT) during the pregnancy of the youngest child to protect against neonatal tetanus. The proportion of women with TT protection is higher in rural areas, among women over 25 years of age and among those who can neither read nor write.

As for vitamin A supplementation, less than one in five (18%) mothers of children aged 0-23 months received a dose of vitamin A within two months following the birth of the youngest child. Luiza was one of the Supervision Areas with lower performance in vitamin A supplementation among mothers during the post natal period for their youngest child.

With regard to skilled birth attendance, 78% of mothers of children 0-23 months were attended by trained personnel during the delivery of their youngest child. This percentage is highest among mothers living in urban areas, among those under 25 years of age, and among mothers who can read and write. Nearly eight out of ten (79%) mothers of children 0-23 months gave birth in health facilities. In rural areas, 26% of mothers gave birth outside health facilities. Kole and Kamina were the two Supervision Areas that registered lower performance with regard to assisted deliveries by trained personnel.

The survey also revealed that postnatal care practices are low in IHP target areas: less than one-fifth (18%) of mothers of children 0-23 months were examined by qualified medical personnel within the three days following birth.

Less than four out of ten (38%) mothers of children 0-23 months have heard about fistula. These mothers are more likely in rural areas, have been in contact with a health care professional, and are over 25 years of age. Four Supervision Areas (Mwene Ditu, Kamina, Kolwezi and Uvira) had weaker knowledge about fistula.

### **HIV/AIDS and Sexual Behaviors**

While almost all women aged 15-49 years (96%) have heard about HIV/AIDS, only 53% know two main ways to prevent the HIV virus. Less than one out of five (17%) women of the same age have a thorough knowledge of HIV, meaning they can correctly identify two ways to prevent HIV, know that a healthy person can have the virus, and can reject two misconceptions about HIV transmission. In addition,

slightly more than two out of five women (43%) know three ways HIV/AIDS can be transmitted from mother to child.

As for HIV counseling and testing, the survey revealed that only one-third (33%) of women aged 15-49 years have had an HIV test during the last 12 months and received their results.

The results of the LQAS analysis show areas of supervision with poor performance as follows: Kole and Kamina for knowledge of HIV/AIDS transmission; Kamina and Uvira for the transmission of HIV from mother to child; and Mwene Ditu, Kole, Tshumbe and Kamina for testing and knowledge of HIV status.

### **Water and Sanitation**

With regard to water and sanitation practices, 42% of surveyed mothers reported drinking water from an improved source. This proportion is higher in urban areas and among mothers who can read and write. Among mothers living in households using unimproved water sources, very few of them (1.7%) treat the water with appropriate methods.

The survey also revealed that 12% of mothers use improved toilets, but only 6% of them use improved non-shared toilets. Almost three-quarters (74%) of surveyed households use unimproved toilets, and 14% of families live in households that practice defecation in open air. Very few households (6%) have a place for hand washing. However, nearly half of families (46%) reported living in households with soap somewhere in the house.

When analyzing local areas, Luiza, Kole and Tshumbe predominantly showed poor performance in the use of improved sources of drinking water and the presence of soap somewhere in the household.

The completion of the IHP baseline survey provides an assessment of the knowledge, practices, and coverage of key health areas in the 80 target health zones of the project. Findings from this cross-sectional survey should assist IHP to deliver high-impact interventions and activities in ways that maximize project effectiveness and efficiency.

Of particular importance are the adoption of behavior change and communication strategies with a small number of key messages that can be delivered through preferred information sources for health and nutrition through formal networks at both health facility and community levels that include doctors, nurses, community health workers, and health educators.

As there are a number of health issues facing young children, mothers and women of reproductive age – particularly young women – integrated strategies for the effective delivery of essential health services at both health facility and community levels should be a priority.

The use of the LQAS methodology provides information not only for the entire project area but also at the local level by identifying high- and low-performing Supervision Areas. This will greatly help IHP managers to prioritize project resources to set up realistic end-of-project targets and improve performance of Supervision Areas towards the achievement of those targets.

Finally, the findings of this baseline study should help other USAID implementing partners working in DRC to improve the health of women and children. IHP should maximize synergies with those partners

by sharing approaches, tools, and strategies for reaching young children, their mothers, and young women of reproductive age with life-saving interventions.

### ANNEX 3: IHP DRAFT PERFORMANCE MONITORING PLAN

The following is an illustrative 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. Upon completion of the baseline study, baseline and end-of-project target figures will be confirmed and/or established, and annual benchmarks will be determined. 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	Base-line*	Annual Benchmarks					End-of-Project Target*	Means of Verification		
			Yr 1	Yr 2	Yr 3	Yr 4	Yr 5		Data Source	Frequency	Person Responsible
<b>USAID/DRC/IHP Objective: increase use of high-impact health services, products, and practices for FP, MNCH, nutrition, malaria, NTDs, TB, HIV&amp;AIDS, and WASH in target health zones</b>											
<b>FP:</b> Couple years of protection (CYP) provided by family planning (FP) services	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	Annually	M&E Specialist HMIS Officers
<b>FP:</b> # of new family planning (FP) acceptors of modern method in FP clinics	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	375,077	386,329	397,919	409,856	422,152	422,152	HMIS	Annually	M&E Specialist HMIS Officers
<b>FP:</b> Number of service delivery points providing family planning (FP)	Number of USG-supported service delivery points	1,321	1,423	1,423	1,423	1,423	1,423	1,423	HMIS	Annually	M&E Specialist HMIS

counseling or services	(excluding door-to-door CBD) providing FP counseling or services, disaggregated by type of service.											Officers
<b>MNCH:</b> # of antenatal care (ANC) visits by skilled providers from health facilities	# of antenatal care (ANC) visits 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	Annually	M&E Specialist HMIS Officers	
<b>MNCH:</b> Number of deliveries with a skilled birth attendant (SBA)	Number of deliveries with a skilled birth attendant (SBA) in the IHP target area.	351,073	365,116	379,721	394,909	410,706	427,134	427,134	HMIS	Annually	M&E Specialist HMIS Officers	
<b>MNCH:</b> # of women receiving Active Management of the Third Stage of Labor (AMTSL)	Number of women giving birth who received Active Management of the Third Stage of Labor (AMSTL) through USG-supported programs/IHP target area.	258,938	277,064	296,458	317,210	339,415	363,174	363,174	HMIS	Annually	M&E Specialist HMIS Officers	
<b>MNCH:</b> Number of postpartum newborn visits within 3 days of birth	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	Annually	M&E Specialist HMIS Officers	
<b>MNCH:</b> Number of newborn receiving essential newborn care	Number of new infants who received essential newborn care from trained facility, outreach or community health workers through USG-	323,516	336,457	349,915	363,912	378,468	393,607	393,607	HMIS	Annually	M&E Specialist HMIS Officers	

	support programs/IHP target area.										
<b>MNCH:</b> Number of newborns receiving antibiotic treatment for infection from appropriate health workers	Number of newborn infants identified as having possible infection who received antibiotic treatment from appropriate trained facility, outreach or community health workers through USG-support programs/IHP target area.	14,529	14,965	15,414	15,876	16,353	16,843	16,843	HMIS	Annually	M&E Specialist HMIS Officers
<b>MNCH:</b> Number cases of child pneumonia treated with antibiotics by trained facility or community health workers	Number of cases of child pneumonia treated with antibiotics by trained facility or community health worker in USG-supported programs/IHP target area.	430,171	451,680	474,264	497,977	522,876	549,019	549,019	HMIS	Annually	M&E Specialist HMIS Officers
<b>MNCH:</b> Number of cases of child diarrhea treated	Number of cases of child diarrhea treated through USG-support programs/IHP target area with: a) Oral Rehydration Therapy (ORT) b) Zinc supplements	292,675	307,309	322,674	338,808	355,748	373,536	373,536	HMIS	Annually	M&E Specialist HMIS Officers
<b>MNCH:</b> Number of children less than 12 months of age who received DPTHB3	Number of children less than 12 months who received DPT3 in a given year from USG supported programs/IHP target area.	324,772	344,258	364,914	386,809	410,017	434,618	434,618	HMIS	Annually	M&E Specialist HMIS Officers

<b>MNCH:</b> 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	Annually	M&E Specialist HMIS Officers
<b>TB:</b> Case notification rate in new sputum smear positive pulmonary TB cases per 100,000	<u>Numerator:</u> Number of new sputum smear positive pulmonary TB cases reported in the past year <u>Denominator:</u> Total population in the specified geographic area (x 100,000)	17115	17626	18156	18700	19261	19839	19839	Health facility records	Annually	M&E Specialist HMIS Officer
<b>TB:</b> Percentage of all registered TB patients who are tested for HIV	<u>Numerator :</u> Number of registered TB patients ( over a given time period ) who are tested for HIV <u>Denominator :</u> Total number of registered TB patients ( over the same time period)	50%	50%	60%	70%	80%	90%	90%	Health facility records	Annually	M&E Specialist HMIS Officer
<b>TB:</b> Percent of the estimated number of new smear-positive pulmonary TB cases that were detected under DOTS	<u>Numerator :</u> Number of new smear positive TB cases detected under DOTS programs <u>Denominator :</u> Estimate number of new smear positive TB cases country wide	83%	85%	87%	90%	93%	95%	95%	Health facility records	Annually	M&E Specialist HMIS Officer
<b>TB:</b> Treatment success rate in USG-assisted DOTS Plus programs to treat MDR TB patients	<u>Numerator:</u> Number of category IV TB patients registered in a specific time period that were cured plus the number that completed	50%	55%	60%	65%	70%	75%	75%	Health facility records	Annually	M&E Specialist HMIS Officer

	treatment in the same specified time period. <u>Denominator</u> : Total number of category IV TB cases registered in the same specified time period										
Fistula treatment: #/% of fistula cases repaired with appropriate reintegration support	<u>Numerator</u> : # of fistula cases repaired <u>Denominator</u> : Total # of women with fistula cases reported in IHP target area	514	75	300	300	480	480	1635	Health facility records	Annually	M&E Specialist HMIS Officer
<u>HIV/PMCT</u> : Number of pregnant women seen for ANC in PMTCT facilities	Number of pregnant women seen for ANC in the facilities who offering the advices to prevent mother-to-child transmission	89,082	96,209	102,943	110,149	117,860	126,110	126,110	Health facility records	Semi-annually	M&E Specialist HMIS Officer
<u>HIV/PMCT</u> : Number of pregnant women receiving HIV counseling ***	Number of pregnant women who received a counseling services for HIV ( advices to prevent mother-to-child transmission)	87,639	96,209	102,943	110,149	117,860	126,110	126,110	Health facility records	Semi-annually	M&E Specialist HMIS Officer
<u>HIV/PMCT</u> : Number of pregnant women receiving HIV counseling and testing ***	Number of pregnant women who received testing for HIV and counseling for safe infant feeding practices	76,216	76,967	82,354	88,119	94,288	100,888	100,888	Health facility records	Semi-annually	M&E Specialist HMIS Officer
<u>HIV/PMCT</u> : Number of pregnant women receiving HIV counseling and testing; and receiving their test results*	Number of pregnant women who were tested for HIV and know their results	75,091	76,967	82,354	88,119	94,288	100,888	100,888	Health facility records	Semi-annually	M&E Specialist HMIS Officer

<u>HIV/PMTCT</u> :Number of pregnant women who tested positive*	Number of pregnant women who were tested positive HIV	659	1,231	1,318	1,410	1,509	1,614	1,614	Health facility records	Semi-annually	M&E Specialist HMIS Officer
<u>HIV/PMCT</u> : Number of pregnant women tested HIV positive who receive test result*	The number of women with know (positive) HIV infection attending ANC for a new pregnancy over the last reporting period	585							Health facility records	Semi-annually	M&E Specialist HMIS Officer
			1206	1292	1382	1494	1598	1598			
<u>HIV/PMTCT</u> :Number of PMTCT health facilities offering PMTCT services*	PMCT+ sites is a service outlet that provides a minimum package of services which includes HIV counseling and testing for pregnant women	137	137	187	250	350	400	400	Health facility records	Semi-annually	M&E Specialist HMIS Officer
<u>HIV/PMTCT</u> : Number of pregnant women provided with a complete course of antiretroviral prophylaxis for PMTCT*	Number of HIV-positive pregnant women who received and complete course antiretrovirals to reduce risk of mother-to-child transmission	413	985	1,054	1,128	1,207	1,291	1,291	Health facility records	Semi-annually	M&E Specialist HMIS Officer
<u>HIV/PMTCT</u> : Number of newborns who received a complete course of antiretroviral prophylaxis***	Number of HIV-positive newborns who received antiretrovirals to reduce risk of mother-to-child transmission	273	1,170	1,252	1,339	1,433	1,533	1,533	Health facility records	Semi-annually	M&E Specialist HMIS Officer
<u>HIV/PMTCT</u> : Number of partners/husbands of pregnant women who receive HIV counseling and testing and receive their results*	Number of husbands of pregnant women positive HIV who received antiretrovirals	7,783	15,513	17,431	19,451	21,575	23,810	23,810	Health facility records	Semi-annually	M&E Specialist HMIS Officer
<u>HIV/PMTCT</u> : Number of women receiving CTX and MVI post	Number of women positive HIV who received CTX and MVI	756	1,231	1,318	1,410	1,509	1,614	1,614	Health facility records	Semi-annually	M&E Specialist HMIS Officer

counseling*											
HIV/PMTCT: Number of newborns receiving CTX and MVI *	Number of newborns who received CTX and MVI	203	1,170	1,252	1,339	1,433	1,533	1,533	Health facility records	Semi-annually	M&E Specialist HMIS Officer
<b>IR 1: Access to and availability of key family health care services and products in target health zones increased (Component 1)</b>											
<b>IR 1.1: Facility-based health care services and products (provincial hospitals and district health centers) in target health zones increased</b>											
#/% 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	Quarterly	M&E Specialist GRH Manager
#/% 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	Quarterly	M&E Specialist HC Director
# of USG-assisted service delivery points experiencing stock-outs of specific tracer drugs	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.	16%	12%	10%	8%	6%	5%	5%	Facility (GRH and HC) records	Quarterly	M&E Specialist HMIS Officer
# of insecticide treated nets (ITNs) distributed that were purchased or subsidized with USG funds	# of ITNs purchased or subsidized with USG funds that were distributed within the IHP target area	589,753	800,000	800,000	800,000	tbd	tbd	tbd	HMIS, IHP records	Annually	M&E Specialist, HMIS Officers
#/% of General Referral Hospitals (GRHs) offering fistula repair	Numerator: # of GRHs that offer fistula repair Denominator: Total # of GRHs in the IHP target area	3	3	5	5	8	8	8	IHP records	Semi-annually	M&E Specialist HMIS Officer

IR 1.2: Community-based health care services and products in target health zones increased											
#/% 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
#/% of communities with FP commodities distribution system	Numerator: # of IHP target communities using a distribution system for FP commodities Denominator: Total # of communities in IHP target area	28%	38%	40%	50%	55%	60%	60%	IHP records	Quarterly	M&E Specialist
# 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	291,180	319,980	348,780	377,580	377,580	IHP records	Annually	M&E Specialist
# 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, i.e., connection to a public sewer, connection to a septic system, pour-flush latrine, simple pit latrine, and ventilated improved pit (VIP) latrine.	123,284	124,784	126,284	127,784	129,284	130,784	130,784	IHP records	Annually	M&E Specialist

<b>IR 1.3: Engagement of provincial management with health zones and facilities to improve service delivery increased</b>											
#/% of senior LDP teams that have achieved their desired performance according to indicators in their action plans within six months of completing the LDP	Desired results achieved by senior LDP teams improves organizational performance and service delivery of health zones and facilities	23 (29%)	23 (29%)	35 (44%)	52 (65%)	80 (100%)	80 (100%)	80 (100%)	LDCP training reports	Semi-annually	LDP Coordinator M&E Specialist
#/% of HZs with validated action plans	<u>Numerator</u> : # HZ with validated actions plans <u>Denominator</u> : Total # HZ in IHP target area	80%	90%	100%	100%	100%	100%	100%	IHP records	Annually	M&E Specialist
<b>IR 2: Quality of key family health care services in target health zones increased (Component 1)</b>											
<b>IR 2.1: Clinical and management capacity of health care providers increased</b>											
# 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 childhood illness	15%	25%	35%	45%	55%	65%	65%	Rapid health facility (GRH and HC) survey	Semi-annually	M&E Specialist HMIS Officer
# 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
<b>IR 2.2: Minimum quality standards for health facilities (provincial hospitals and district health centers) and services developed and adopted</b>											
#/% of health facilities meeting all nine FOSACOF minimum standards, disaggregated by type of health facility	<u>Numerator</u> : # of health facilities meeting all nine FOSACOF minimum standards <u>Denominator</u> : Total # of facilities	8%	22%	36%	51%	65%	79%	79%	HF (GRH and HC) records	Semi-annually	M&E Specialist HMIS Officer

<b>IR 2.3: Referral system for primary health care prevention, care and treatment between community structures and health facilities (district and provincial levels) institutionalized</b>											
#/% 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
#/% of patients referred to GRHs, disaggregated by illness, gender, and age	# of patients (adults and children) referred to GRHs by a CHW or health care provider	5%	10%	15%	20%	25%	25%	25%	HF records	Quarterly	HMIS Officer
<b>IR 3: Knowledge, attitudes, and practices to support health-seeking behaviors in target health zones increased (Component 1)</b>											
<b>IR 3.1: Evidence-based health sector-community outreach linkages –especially for women, youth and vulnerable populations– established</b>											
# 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
% of NGOs representing women, youth and vulnerable groups participating in coordination meetings	<u>Numerator:</u> # of NGOs representing women, youth, and vulnerable groups attending NGO coordination meetings <u>Denominator:</u> # of NGOs representing women, youth and vulnerable groups registered in DRC	ND	15%	20%	25%	30%	40%	40%	IHP records	Annually	BCC Technical Advisor
# 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
# Community health action plans created	# Community health action plans developed by community members and reviewed by IHP staff	ND	250	350	700	1,200	1,423	1,423	IHP records	Quarterly	BCC Technical Advisor

# 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
<b>IR 3.2: Health advocacy and community mobilization organizations strengthened</b>											
# 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
<b>IR 3.3: Behavior change campaigns involving opinion leaders and cultural influences (people and technologies) launched</b>											
# /%Field staff, Community Relays, and community mobilization organizations integrating BCC tools into activities	# of organizations adopting BCC tools with key messages to adopt healthy practices by targeted population groups	0	100	300	700	1000	1000	1000	IHP records	Quarterly	BCC Technical Advisor
# Health-related stories/reports appearing/broadcasted in local media	# Stories/reports covering health topics promoted through BCC and media outreach activities	0	20	20	60	100	100	100	Media monitoring reports	Quarterly	BCC Technical Advisor
# Communities/people members receiving Education Through Listening (ETL)	# Communities/people completing ETL course	0	tbd	tbd	tbd	tbd	tbd	tbd	IHP records	Quarterly	BCC Technical Advisor
<b>IR 4: Health sector leadership and governance in target provinces improved (Component 2)</b>											
<b>IR 4.1: Provincial health sector policies and national level policies aligned</b>											
#/% of Health Zones adopting health sector policies in alignment with national MOH policies	<u>Numerator:</u> # of Health Zones with policies developed and adopted in line with national MOH policies <u>Denominator:</u> Total # of Health Zones	12%	20%	50%	80%	100%	100%	100%	Health zones records	Annually	M&E Specialist HZ Manager

#/% of Health Zones implementing a well-developed strategic plan in alignment with national MOH strategies	<u>Numerator:</u> # of Health Zones implementing a well-developed strategic plan in line with national MOH policies <u>Denominator:</u> Total # of Health Zones	10%	20%	50%	80%	100%	100%	100%	Health zones records	Annually	M&E Specialist Facilitators HZ Manager
<b>IR 4.2: Evidence-based tools for strategic planning and management decision-making adopted</b>											
# /% of GRHs implementing a well-developed strategic plan in alignment with provincial MOH strategies	A "strategic plan" is a written document that defines how an organization aims to reach its goals and objectives through a series of inputs, activities, and results. The strategic plan usually covers a period of 3 to 5 years, set forth the mission and goals of the organization, prioritizes strategies, and formulates the financial basis for achieving the goals.	5%	20%	50%	80%	100%	100%	100%	GRH records	Annually	Facilitators
% of organizational planning units in GRHs using MIS data as the basis for annual input/output projections	<u>Numerator:</u> # of organizational units having access to and using MIS data as the basis for annual plans during the last planning cycle <u>Denominator:</u> Total # of organizational units that prepared annual plans during the last planning cycle	15%	20%	50%	80%	100%	100%	100%	GRH records	Annually	M&E Specialist HMIS Officer

#/% of Health Zones with a current human resource plan	<u>Numerator:</u> # of Health Zones with a human resource plan that provides the human capacity required to meet the organization's goals <u>Denominator:</u> Total # of Health Zones	20%	20%	50%	80%	100%	100%	100%	Health zone human resource documents	Annually	M&E Specialist HZ Manager
#/% of Health Zones with a performance management system that includes all essential components	<u>Numerator:</u> # of Health Zones with a performance management system that includes three essential components: up-to-date job descriptions, lines of supervision, and joint work planning and performance review <u>Denominator:</u> Total # of Health Zones	10%	20%	50%	80%	100%	100%	100%	Health zone human resource documents	Annually	M&E Specialist HZ Manager
<b>IR 4.3: Community involvement in health policy and service delivery institutionalized</b>											
#/% of Health Zones implementing community-outreach policies promoting health prevention and use of health services developed and implemented	<u>Numerator:</u> # of Health Zones with community outreach policies promoting health prevention and use of health services in place and implemented <u>Denominator:</u> Total # of Health Zones	7%	10%	15%	20%	30%	40%	40%	Health zone records	Annually	M&E Specialist HZ Manager
#/% of community leaders actively involved in health management and services	<u>Numerator:</u> # of community leaders trained and involved in health management and services <u>Denominator:</u> Total # of	15%	20%	30%	40%	50%	60%	60%	IHP records	Annually	M&E Specialist

	community leaders									
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\* Available baseline and end-of-project target figures included in this illustrative PMP are estimates and will be confirmed and/or established upon completion of the baseline study.

## ANNEX 4: 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 I 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.  
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
- 7.2 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, PoNC, CPS, etc) as priority activities of their monthly field visits.
- 7.4 Provide technical, logistical and financial support to Vit 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). RDTs 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 Kasai.
- 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, 5<sup>th</sup> 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

- 18.7 implementing PBF.  
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 Reports.

Activity 23 **Planning**

- 23.1 Prepare IHP work plan for year 2.  
23.2 Organize a work planning workshop.

## ANNEX 5: ANALYSIS OF VACCINATION DATA FOR JAN – MAY 2011

N°	Aires de Santé	Compilation des données de population et de Couverture vaccinale							Analyse des problèmes						Catégorie 1,2,3,4	Nbre ENA
		Pop cible (3,49 %) Men suel	Doses administrées			Couvertures Vaccinales			Enfants Non vaccinés		Taux d'abandon		Identification problèmes			
			DT C- Hep B - Hib 1	DT C- Hep B - Hib 3	VA R	DT C- He pB - Hi b1	DT C- He pB - Hi b3	VA R	DT C- Hep B- Hib 1- VA R	Pen t 1 - Pen ta 3	Access ibilité	Utili satio n				
			c		e	f	g	h	i	j	k	l	m	n		
1	Bilomba	1419	1198	1149	1079	84 %	81 %	76 %	270	340	4%	10 %	Mauvaise	Bonne	Cat. 3	221
2	Dibaya	2356	2952	2773	1960	12 %	11 %	83 %	-417	396	6%	34 %	Bonne	Bonne	Cat. 1	-596
3	Lubodayi	2407	2010	1935	1921	84 %	80 %	80 %	472	486	4%	4%	Mauvaise	Bonne	Cat. 3	397
4	Mutoto	2046	1510	1530	1560	74 %	75 %	76 %	516	486	-1%	-3%	Mauvaise	Mauvaise	Cat. 4	536
5	Ndekeshia	2536	2608	2493	1812	10 %	98 %	71 %	43	724	4%	31 %	Bonne	Bonne	Cat. 1	-72
6	Tshikaji	1882	1343	1273	1317	71 %	68 %	70 %	609	565	5%	2%	Mauvaise	Bonne	Cat. 3	539
7	Kalomba	2368	1922	1933	1658	81 %	82 %	70 %	435	710	-1%	14 %	Mauvaise	Mauvaise	Cat. 4	446
8	Luiza	2700	2197	2176	1987	81 %	81 %	74 %	524	713	1%	10 %	Mauvaise	Bonne	Cat. 3	503
9	Yangala	2405	1868	2006	1902	78 %	83 %	79 %	399	503	-7%	-2%	Mauvaise	Mauvaise	Cat. 4	537
10	Bulape	2668	1532	1445	1868	57 %	54 %	70 %	1223	800	6%	-22 %	Mauvaise	Bonne	Cat. 3	1136
11	Dekeke	2295	1379	1099	1580	60 %	48 %	69 %	1196	715	20 %	-15 %	Mauvaise	Mauvaise	Cat. 4	916
12	Tshudi-Loto	1153	1043	1022	780	90 %	89 %	68 %	131	373	2%	25 %	Bonne	Bonne	Cat. 1	110
13	Vanga-Kete	1967	1605	1510	1532	82 %	77 %	78 %	457	435	6%	5%	Mauvaise	Bonne	Cat. 3	362
14	Omendjadi	2073	1699	1629	1530	82 %	79 %	74 %	444	543	4%	10 %	Mauvaise	Bonne	Cat. 3	374
15	Lodja	2931	2486	2354	2229	85 %	80 %	76 %	577	702	5%	10 %	Mauvaise	Bonne	Cat. 3	445

Critère
TCV DTC1
90%
T abandon
10%

16	Kole	1502	1336	1307	1299	89 %	87 %	87 %	195	203	2%	3%	Mauvaise	Bonne	Cat. 3	166
17	Lomela	1761	1523	1452	1408	86 %	82 %	80 %	309	353	5%	8%	Mauvaise	Bonne	Cat. 3	238
18	Bena-Dibele	1652	1321	1083	1576	80 %	66 %	95 %	569	76	18 %	-19 %	Mauvaise	Mauvaise	Cat. 4	331
19	Dikungu	2122	1977	1897	1861	93 %	89 %	88 %	225	261	4%	6%	Bonne	Bonne	Cat. 1	145
20	Djalo-Ndjeka	1274	1080	1040	1031	85 %	82 %	81 %	234	243	4%	5%	Mauvaise	Bonne	Cat. 3	194
21	Katako-Kombe	1828	1730	1619	1547	95 %	89 %	85 %	209	281	6%	11 %	Bonne	Bonne	Cat. 1	98
22	Minga	2429	1951	1825	2021	80 %	75 %	83 %	604	408	6%	-4%	Mauvaise	Bonne	Cat. 3	478
23	Ototo	2053	1718	1623	1581	84 %	79 %	77 %	430	472	6%	8%	Mauvaise	Bonne	Cat. 3	335
24	Tshumbe	1544	1487	1369	1189	96 %	89 %	77 %	175	355	8%	20 %	Bonne	Bonne	Cat. 1	57
25	Wembo-Nyama	1472	1242	1182	1168	84 %	80 %	79 %	290	304	5%	6%	Mauvaise	Bonne	Cat. 3	230
26	Bibanga	2361	2216	2098	2006	94 %	89 %	85 %	263	355	5%	9%	Bonne	Bonne	Cat. 1	145
27	Dibindi	4193	3864	3482	3579	92 %	83 %	85 %	711	614	10 %	7%	Bonne	Bonne	Cat. 1	329
28	Lusambo	1438	1290	1218	991	90 %	85 %	69 %	220	447	6%	23 %	Mauvaise	Bonne	Cat. 3	148
29	Mpokolo	4813	3806	3512	3698	79 %	73 %	77 %	1301	1115	8%	3%	Mauvaise	Bonne	Cat. 3	1007
30	Pania Mutombo	1238	1042	974	968	84 %	79 %	78 %	264	270	7%	7%	Mauvaise	Bonne	Cat. 3	196
31	Kalenda	3311	2057	2087	2201	62 %	63 %	66 %	1224	1110	-1%	-7%	Mauvaise	Mauvaise	Cat. 4	1254
32	Kamiji	1525	1505	1544	1409	99 %	10 %	92 %	-19	116	-3%	6%	Bonne	Mauvaise	Cat. 2	20
33	Kanda-Kanda	3558	3024	2937	3054	85 %	83 %	86 %	621	504	3%	-1%	Mauvaise	Bonne	Cat. 3	534
34	Luputa	4554	3544	3286	3759	78 %	72 %	83 %	1268	795	7%	-6%	Mauvaise	Bonne	Cat. 3	1010
35	Mwene-Ditu	6645	5603	5432	5732	84 %	82 %	86 %	1213	913	3%	-2%	Mauvaise	Bonne	Cat. 3	1042
36	Wikong	1865	1532	1365	1476	82 %	73 %	79 %	500	389	11 %	4%	Mauvaise	Mauvaise	Cat. 4	333
37	Kinkondja	3781	2573	2380	2988	68 %	63 %	79 %	1401	793	8%	-16 %	Mauvaise	Bonne	Cat. 3	1208
38	Lwamba	1816	1603	1580	1504	88 %	87 %	83 %	236	312	1%	6%	Mauvaise	Bonne	Cat. 3	213
39	Malemba-Nkulu	4088	2381	1669	2350	58 %	41 %	57 %	2419	1738	30 %	1%	Mauvaise	Mauvaise	Cat. 4	1707
40	Mukanga	3163	1711	1600	2069	54 %	51 %	65 %	1563	1094	6%	-21 %	Mauvaise	Bonne	Cat. 3	1452

41	Mulongo	4570	3281	2997	3456	72%	66%	76%	1573	1114	9%	-5%	Mauvaise	Bonne	Cat. 3	1289
42	Kabongo	5517	4178	3666	3718	76%	66%	67%	1851	1799	12%	11%	Mauvaise	Mauvaise	Cat. 4	1339
43	Kayamba	1493	1311	1240	1278	88%	83%	86%	253	215	5%	3%	Mauvaise	Bonne	Cat. 3	182
44	Kitenge	3872	3887	3722	3450	100%	96%	89%	150	422	4%	11%	Bonne	Bonne	Cat. 1	-15
45	Songa	2593	2244	2049	1777	87%	79%	69%	544	816	9%	21%	Mauvaise	Bonne	Cat. 3	349
46	Dilala	1783	2161	2064	1618	121%	116%	91%	-281	165	4%	25%	Bonne	Bonne	Cat. 1	-378
47	Fungurume	1661	2844	2657	2479	171%	160%	149%	-996	-818	7%	13%	Bonne	Bonne	Cat. 1	-1183
48	Kanzenze	1398	1331	1336	1355	95%	96%	97%	62	43	0%	-2%	Bonne	Mauvaise	Cat. 2	67
49	Lualaba	1493	1855	1665	1969	124%	112%	132%	-172	-476	10%	-6%	Bonne	Mauvaise	Cat. 2	-362
50	Lubudi	3380	1172	1119	1505	35%	33%	45%	2261	1875	5%	28%	Mauvaise	Bonne	Cat. 3	2208
51	Manika	1823	4494	3875	3514	247%	213%	193%	-2052	1691	14%	22%	Bonne	Mauvaise	Cat. 2	-2671
52	Mutshatsha	1061	893	796	846	84%	75%	80%	265	215	11%	5%	Mauvaise	Mauvaise	Cat. 4	168
53	Bunkeya	828	715	577	598	86%	70%	72%	251	230	19%	16%	Mauvaise	Mauvaise	Cat. 4	113
54	Bagira-Kasha	1468	1877	1714	1447	128%	117%	99%	-246	21	9%	23%	Bonne	Bonne	Cat. 1	-409
55	Bunyakiri	2276	2181	2091	1592	96%	92%	70%	185	684	4%	27%	Bonne	Bonne	Cat. 1	95
56	Ibanda	4759	4304	3967	3427	90%	83%	72%	792	1332	8%	20%	Bonne	Bonne	Cat. 1	455
57	Idjwi	3654	2518	2344	2325	69%	64%	64%	1310	1329	7%	8%	Mauvaise	Bonne	Cat. 3	1136
58	Kadutu	2996	3539	3349	3185	118%	112%	106%	-353	-189	5%	10%	Bonne	Bonne	Cat. 1	-543
59	Kalehe	1558	3381	3157	2164	217%	203%	139%	-1599	-606	7%	36%	Bonne	Bonne	Cat. 1	-1823
60	Kalole	2745	1564	1183	1904	57%	43%	69%	1562	841	24%	22%	Mauvaise	Mauvaise	Cat. 4	1181
61	Kalonge	2365	2150	1878	1564	91%	79%	66%	487	801	13%	27%	Bonne	Mauvaise	Cat. 2	215
62	Kamituga	2627	2385	2191	1714	91%	83%	65%	436	913	8%	28%	Bonne	Bonne	Cat. 1	242
63	Kaniola	3011	2169	2137	2012	72%	71%	67%	874	999	1%	7%	Mauvaise	Bonne	Cat. 3	842
64	Katana	1780	2764	2553	2409	155%	143%	135%	-773	-629	8%	13%	Bonne	Bonne	Cat. 1	-984
65	Kaziba	2618	1462	1398	1452	56%	53%	55%	1220	1166	4%	1%	Mauvaise	Bonne	Cat. 3	1156

66	Kitutu	1972	1836	1550	1254	93%	79%	64%	422	718	16%	32%	Bonne	Mauvaise	Cat. 2	136
67	Lulingu	2380	1605	1524	1438	67%	64%	60%	856	942	5%	10%	Mauvaise	Bonne	Cat. 3	775
68	Minova	2946	3305	2770	2292	112%	94%	78%	176	654	16%	31%	Bonne	Mauvaise	Cat. 2	-359
69	Miti-Murghesa	3080	2828	2721	3066	92%	88%	100%	359	14	4%	-8%	Bonne	Bonne	Cat. 1	252
70	Mubumbano	2560	2376	2296	2258	93%	90%	88%	264	302	3%	5%	Bonne	Bonne	Cat. 1	184
71	Mulungu	2084	1654	1405	1059	79%	67%	51%	679	1025	15%	36%	Mauvaise	Mauvaise	Cat. 4	430
72	Mwana	1987	1826	1753	1626	92%	88%	82%	234	361	4%	11%	Bonne	Bonne	Cat. 1	161
73	Mwenga	2065	1930	1750	1248	93%	85%	60%	315	817	9%	35%	Bonne	Bonne	Cat. 1	135
74	Nyangezi	1889	1723	1450	1566	91%	77%	83%	439	323	16%	9%	Bonne	Mauvaise	Cat. 2	166
75	Shabunda Centre	2150	2424	2257	2130	113%	105%	99%	-107	20	7%	12%	Bonne	Bonne	Cat. 1	-274
76	Walungu	3773	3286	3329	3065	87%	88%	81%	444	708	-1%	7%	Mauvaise	Mauvaise	Cat. 4	487
77	Hauts Plateaux d'Uvira	1734	1654	1555	1839	95%	90%	106%	179	-105	6%	-11%	Bonne	Bonne	Cat. 1	80
78	Lemera	2353	2153	1987	1684	91%	84%	72%	366	669	8%	22%	Bonne	Bonne	Cat. 1	200
79	Nundu	3675	2916	2845	2589	79%	77%	70%	830	1086	2%	11%	Mauvaise	Bonne	Cat. 3	759
80	Ruzizi	2172	1911	1751	1364	88%	81%	63%	421	808	8%	29%	Mauvaise	Bonne	Cat. 3	261
81	Uvira	4182	3939	3985	3074	94%	95%	73%	197	1108	-1%	22%	Bonne	Mauvaise	Cat. 2	243
	<b>Total trimestriel</b>	<b>203,521</b>	<b>178,494</b>	<b>166,541</b>	<b>161,490</b>	<b>88%</b>	<b>82%</b>	<b>79%</b>	<b>36980</b>	<b>42031</b>	<b>7%</b>	<b>10%</b>	<b>Mauvaise</b>	<b>Bonne</b>	<b>Cat. 3</b>	<b>25027</b>

## ANNEX 6: SUMMARY OF RESULTS OF THE FOSACOF EVALUATION

### RAPPORT FOSACOF Q3Y1

Au cours du trimestre, 94 formations santinaires dans 19 Zones de santé de trois coordinations PROSANI (Tshumbe, Luiza, et Mwene Ditu) ont réalisé des évaluations sur la qualité de service offert à la population au travers l'outil FOSACOF au mois de Juin. La coordination de Kole avec 4 zones de santé est ne cours d'évaluation.

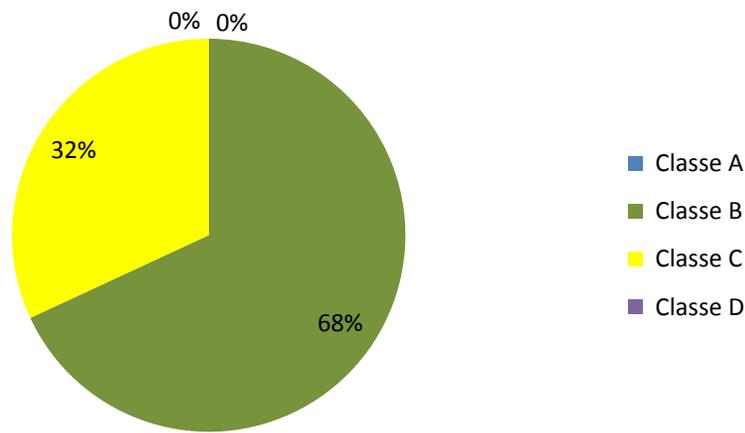
**Tableau 1** : Nombre de formations sanitaires par classe de performance FOSACOF au cours de l'évaluation de mois de Juin 2011.

Coordination	Zone de santé	> 80%	≥50-79%	25-50%	< 25%
TSHUMBE	Dikungu	0	0	4	0
	Ndjalo	0	3	2	0
	Katako	0	2	3	0
	Minga	0	3	2	0
	Ototo	0	1	4	0
	Tshumbe	0	3	2	0
	Wembo	0	1	4	0
MWENE DITU	Mwene Ditu	0	4	1	0
	Kamiji	0	5	0	0
	Kalenda	0	4	1	0
	Luputa	0	5	0	0
	Wikong	0	5	0	0
	Kalenda	0	4	1	0
LUIZA	Bilomba	0	3	2	0
	Dibaya	0	4	1	0
	Kalomba	0	5	0	0
	Luiza	0	2	3	0
	Ndekesha	0	5	0	0
	Yangala	0	5	0	0
TOTAL PROSANI		0	64	30	0

#### **Classification :**

Classe A (> 80%) : Complement fonctionnelle,  
 Classe B (≥50-79%) : Moyennement fonctionnelle,  
 Classe C (25-50%) : Peu fonctionnelle,  
 Classe D (< 25%) : Non fonctionnelle.

## Proportion des structures par classe de performance



### Commentaires :

Au cours du trimestre, aucune structure n'est complètement fonctionnelle soit ayant obtenu plus de 80% sur l'ensemble de critères, 64 structures (soit 68%) évaluées ont une cote variant entre 50 à 79% c'est-à-dire sont moyennement fonctionnelle. Et 30 structures soit 32% sont encore peu fonctionnelle c'est-à-dire dans la classe C, et aucune structure est non fonctionnelle.

Les structures dans la coordination de Mwene ditu ont des meilleures cotes, 90% entre elles sont moyennement fonctionnelle. Le centre de santé de Macici dans la zone de santé de Mwene Ditu a eu la meilleure côte du trimestre 79% suivi du centre de santé Kaninthin dans la zone de santé de Wikong 77%. Ce sont les deux meilleurs centres de santé fosacof évalué durant le trimestre.

Les structures ayant obtenues de faibles cotes durant la période sont celles de la coordination de Tshumbe, il s'agit du centre de santé de Okitodimba 33% dans la zone de santé de Dikungu et le centre de santé de Omeonga dans la zone de santé de avec 36%

La structure qui a gagné plus de points durant la période c'est le centre de santé de Longonya dans la zone de santé de Djalo Ndjeka qui a obtenu 33,8% de points dans l'ensemble de l'évaluation.

L'analyse au niveau de la base de données note qu'aucune structure n'a perdu de points pour l'ensemble des critères durant la période ;

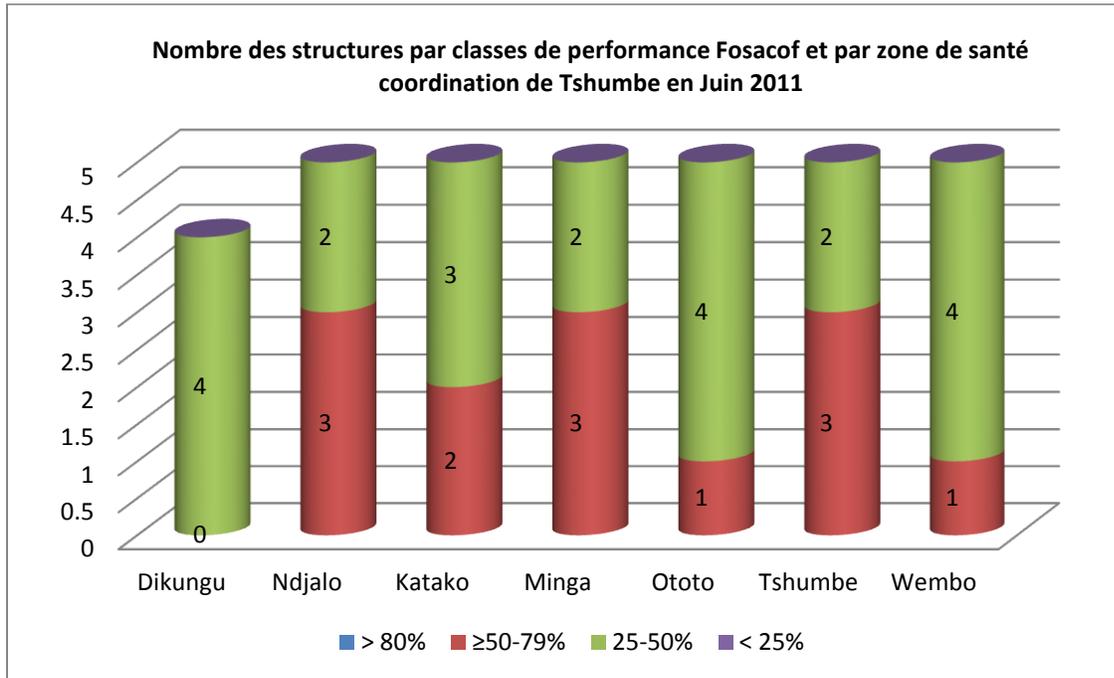
Par rapport aux critères généraux : il est à signaler que les 9 critères ont connu une amélioration durant la période. Les critères : Approche communautaire et Soutien communautaire ont connu une grande évolution et cela suite aux contributions de BCC dans les bureaux de coordinations.

### Synthèse des évaluations FOSACOF par Coordination.

#### I. COORDINATION DE TSHUMBE

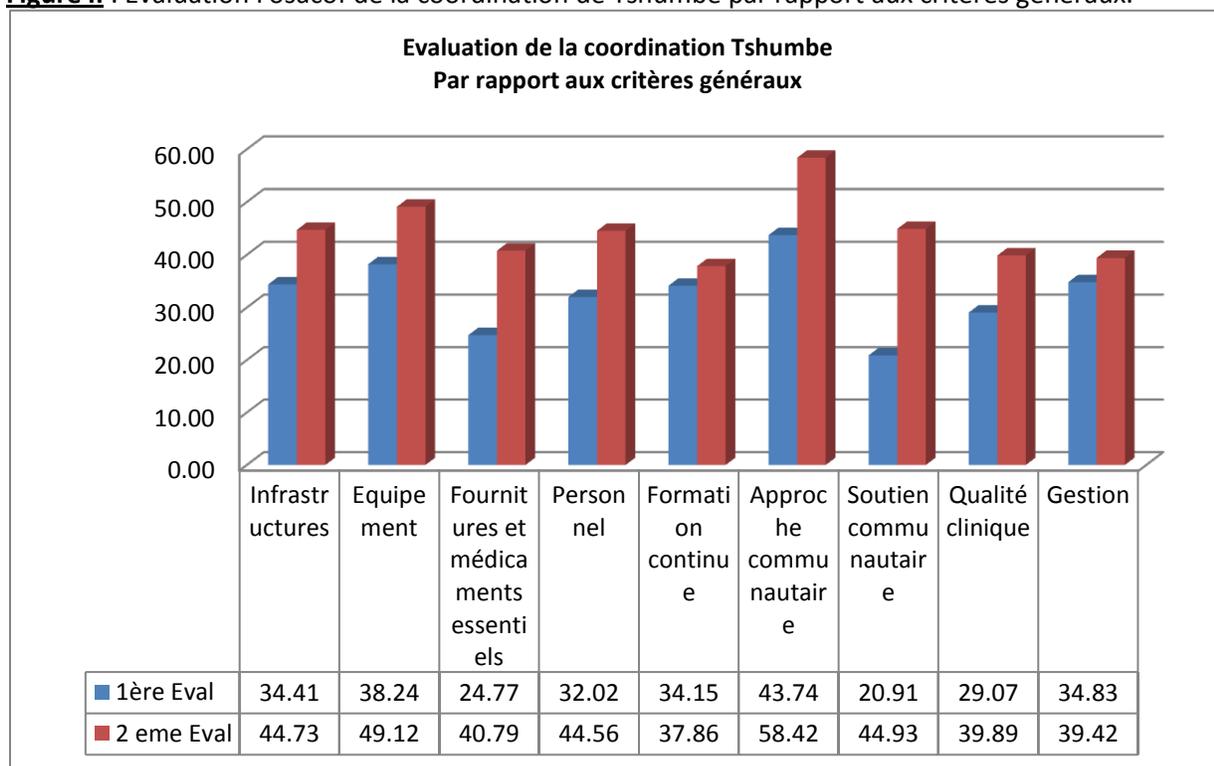
La coordination de Tshumbe a 35 structures Fosacof dans 7 zones de santé, 34 ont été évalué durant la période, la structure de Ovungu dans la zone de santé de Dikungu n'a pas été évaluée à cause de la non disponibilité des prestataires.

**Figure I** : Nombre des structures par classes de performance Fosacof et par zone de santé coordination de Tshumbe en Juin 2011.



**Commentaires:** Dans la coordination de Tshumbe, la plus part des structures évaluées 21 sur 34 soit 62% sont dans la classe Fosacof peu fonctionnelle alors que 13 structures (38%) sont dans la classe moyennement fonctionnelle. Aucune zone de santé a une structure dans la classe A, 3 zones de santé ont 3 structures dans la classe B, une zone de santé a 2 structures dans la classe B. Un peu plus d'efforts seront concentrés dans les structures des zones de santé de Dikungu, Ototo et Wembonyama qui ont peu de structures qui tendent vers devenir complètement fonctionnelle. Classe A.

**Figure II** : Evaluation Fosacof de la coordination de Tshumbe par rapport aux critères généraux.

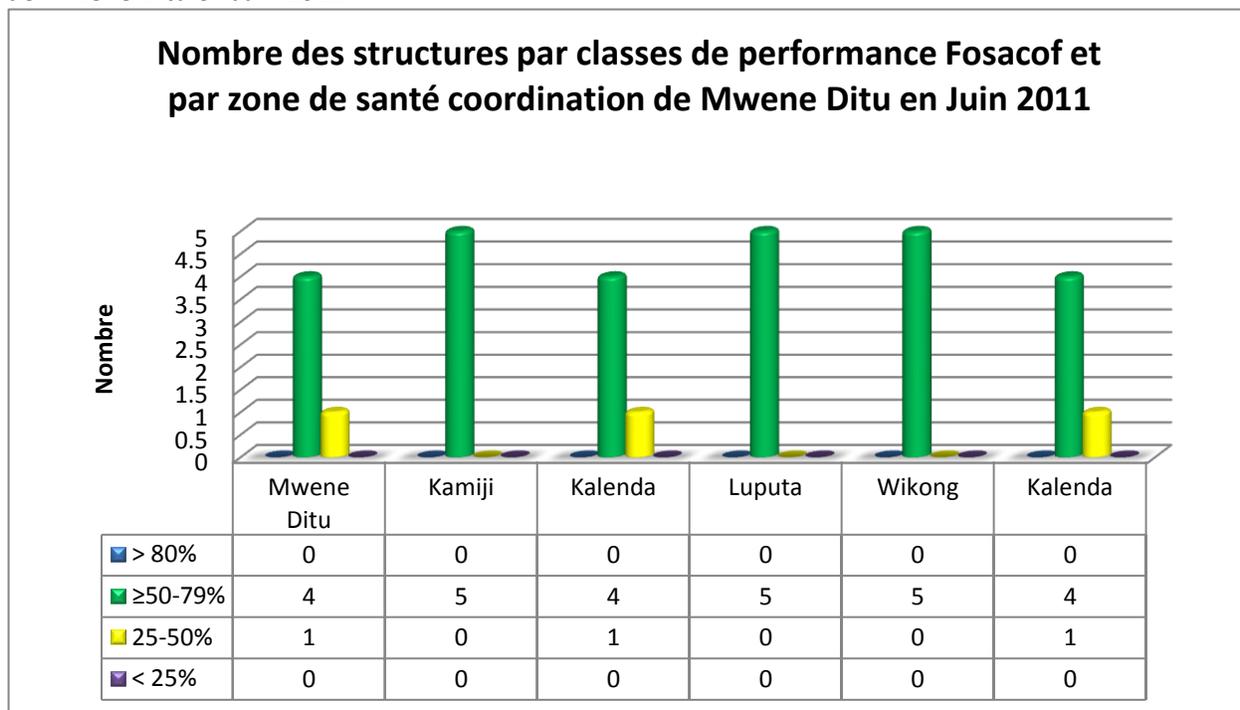


**Commentaires:** En comparant les deux évaluations, on constate une amélioration pour tous les critères généraux; avec plus d'effort concernant les critères soutien communautaire et approche communautaire. Néanmoins aucun critère n'a dépassé le 60% pour la moyenne de la coordination.

## II. COORDINATION DE MWENE DITU

La coordination de Mwene ditu, berceau de Fosacof du projet. Cette coordination 30 structures Fosacof, au cours du trimestre toutes les structures ont été évaluées, La moyenne de cote par critère généraux est de plus de 60%

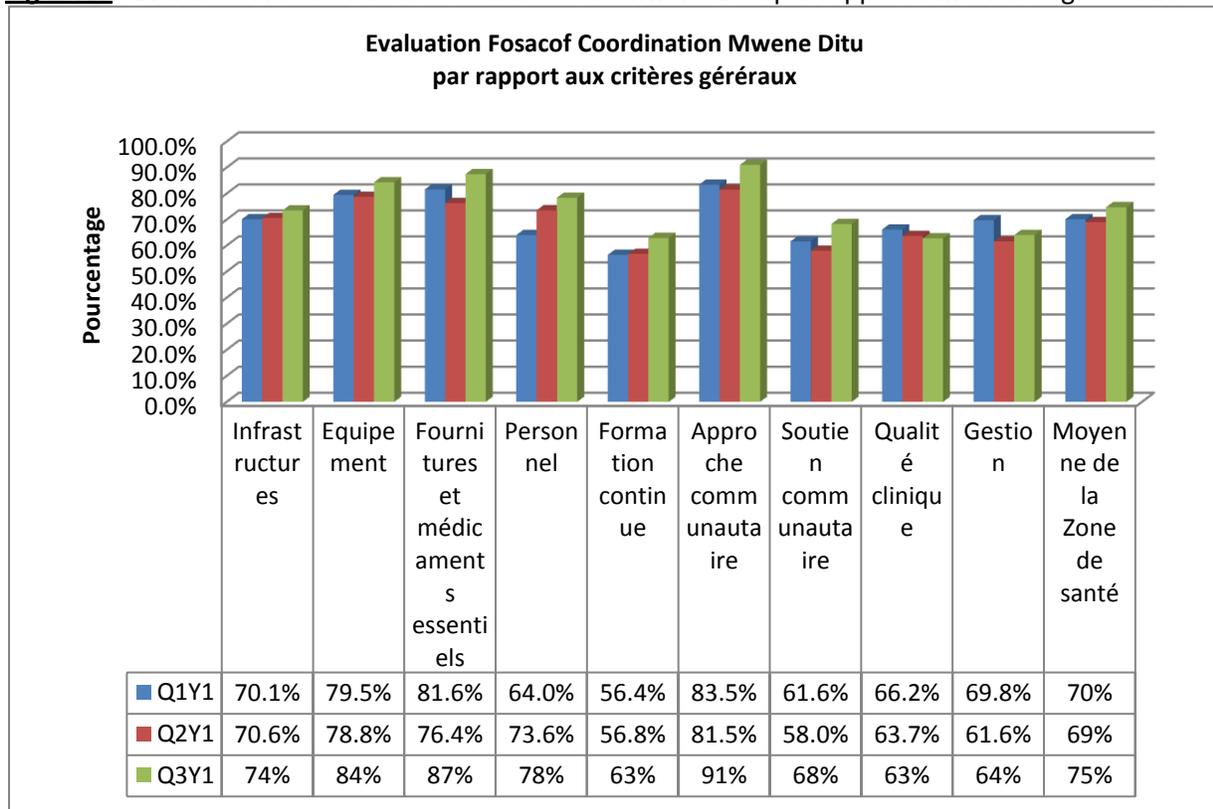
**Figure III** : Nombre des structures par classes de performance Fosacof et par zone de santé coordination de Mwene Ditu en Juin 2011



**Commentaires:** 90% des structures Fosacof sont moyennement fonctionnelles alors que 10 sont peu fonctionnelles.

On note, une bonne évolution des structures dans cette coordination, trois zones de santé ont toutes les structures dans la classe B, cependant trois zones de santé ont encore chacune une structure dans la classe C. Des plans de redressement dans toutes les structures sont élaborés et des discussions avec toutes les parties prenantes sont prévues pour améliorer la performance durant le prochain trimestre.

**Figure IV :** Evaluation Fosacof de la coordination de Mwene Ditu par rapport aux critères généraux.

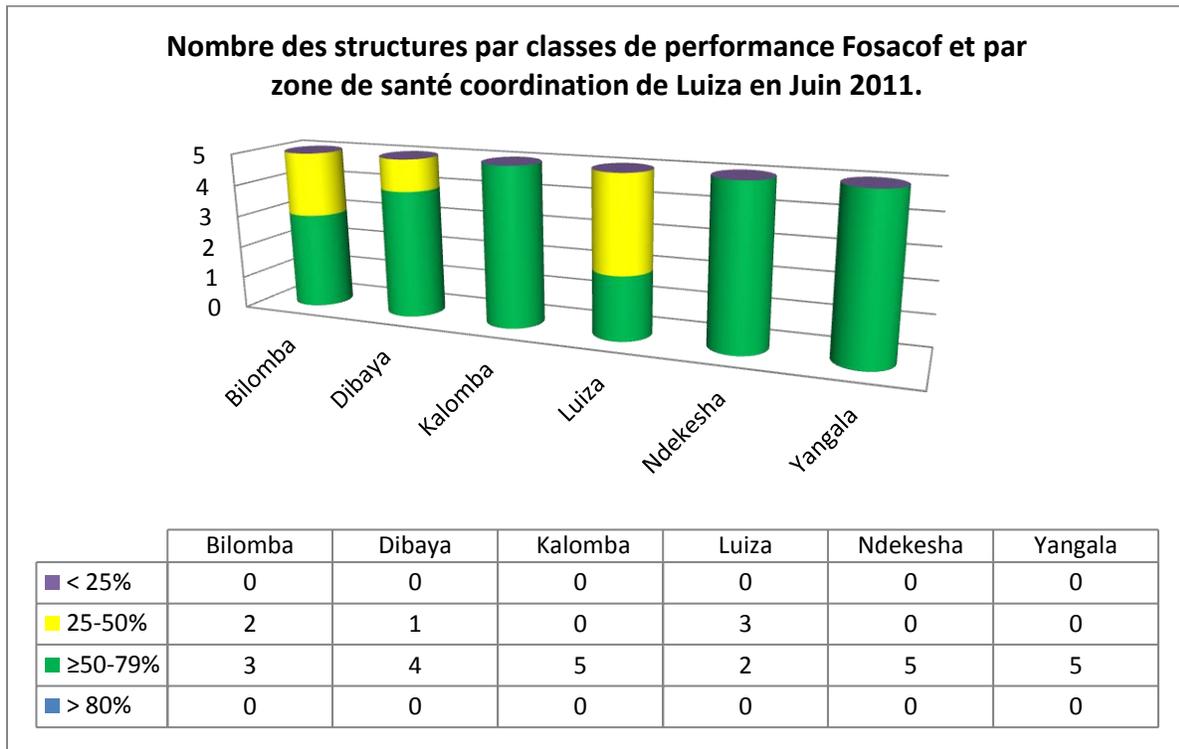


**Commentaires:** Trois évaluations FOSACOF sont réalisés depuis le début du projet PROSANI dans la coordination de Mwene Ditu. On remarque qu’il ya une amélioration surtout lors de la dernière évaluation où tous les critères en moyenne ont de bonne cotation. Les critères approche communautaire, équipement, et fournitures en médicaments essentiels ont dépassé le 80% pour la moyenne de la coordination.

### III. COORDINATION DE LUIZA

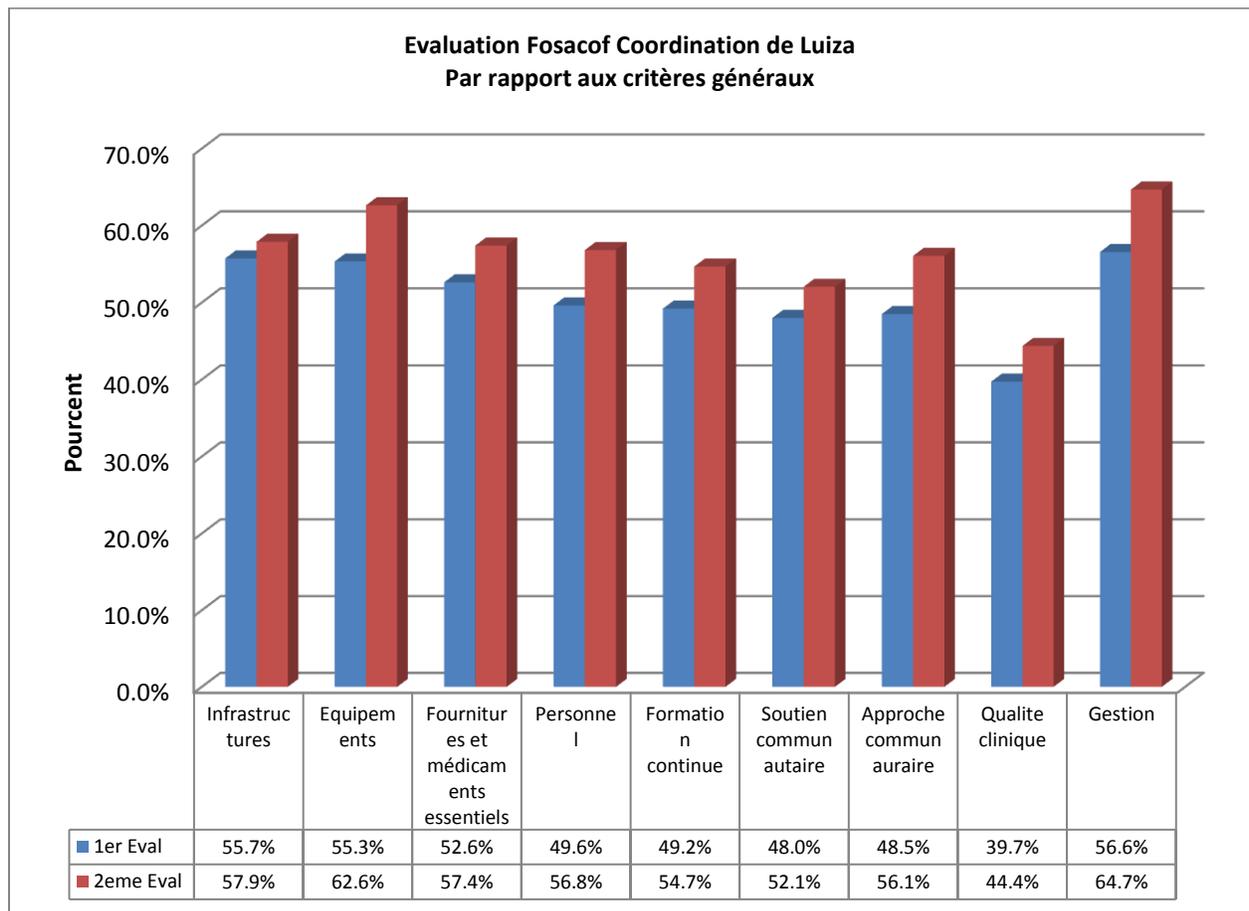
L'une de coordination du projet Prosani a aussi 30 structures Fosacof, et toutes les structures ont été évaluées durant le trimestre ;

**Figure V** : Nombre des structures par classes de performance Fosacof et par zone de santé coordination de Luiza en Juin 2011.



**Commentaires:** 24 structures Fosacof sont moyennement fonctionnelles alors que 6 sont encore peu fonctionnelles, à l'occurrence de la coordination de Mwene ditu, 3 zones de santé ont toutes leurs structures dans la classe B (moyennement fonctionnelle), cependant les zones de santé de Bilomba et Luiza nécessitent un suivi du plan de redressement mensuel car détiennent encore des structures dans la classe C.

**Figure VI** : Evaluation Fosacof de la coordination de Luiza par rapport aux critères généraux.



**Commentaires:** comme dans les deux premières coordinations, on note une évolution favorable. Ici c'est le critère gestion qui mieux coté dans les structures de manière générale mais encore inférieur à 80%.

## ANNEX 7: EVALUATION OF COMMUNITY HEALTH SITES – SOUTH KIVU

### ETAT DES LIEUX DES SITES DE SOINS COMMUNAUTAIRES AU SUD KIVU.

Les ZS ayant intégrées les sites de soins communautaires dans la province sont :

No	DISTRICT SANIT.	ZONES DE SANTE	Nbre de SSC	PARTENAIRE D'APPUI	FONCTIONNEL	OBSERVATION
1	Nord	Kalonge	7	IHP	4	Seuls 4 ssc rapportent à ce jour
		Bunyakiri	10	IHP	3	Absence d'un AC formé en SSC pour le suivi des activités
		Idjwi	5	IHP	0	ECZS formée en SSC a été désaffectée de la ZS
		Kalehe	5	IRC	4	Opérationnels mais nécessitent l'intensification des supervisions provinciales
2	Sud	Ruzizi	5	IHP	0	Insécurité dans les aires d'intégration des SSC (Ndunda)
		Lemera	5	IHP	0	Non implication de l'ECZ dans l'encadrement de relais formés.
		H.Plateau	5	OMS	0	peu d'intérêt du partenaire car ne constituant pas une urgence dans son programme et AC non formé.
		Uvira	5	IHP	2	Opérationnels mais ne rapportent pas par manque d'AC encadreur.
		Nundu	5	IHP	2	Opérationnels mais ne rapportent pas par manque d'AC encadreur.

3	Centre	Nyangezi	5	IHP	0	SS non opérationnels car rupture prolongé en ME du site.
		Kaziba	5	IHP	4	Timide fonctionnement par manque des supervisions.
		Mwana	5	IHP	0	SS non opérationnels car rupture prolongé en ME du site.
		Mubumbano	5	IHP	0	SS non opérationnels car rupture prolongé en ME du site.
4	Ouest	Mwenga	5	IHP	4	Opérationnel mais nécessite la supervision du niveau intermédiaire.
		Kamituga	5	IHP	0	SS non opérationnels car rupture prolongé en ME du site.
		Kitutu	5	IHP	0	SS non opérationnels car rupture prolongé en ME du site et manque d'AC.

NB : Les besoins dans l'intégration des SSC reste réels dans la province les enfants des AS à accès difficile, mais leur opérationnalité est confrontée à diverses difficultés :

- La non fidélisation de l'AC dans la ZS.
- Approvisionnement irrégulier en ME de ssc
- Faible capacité institutionnelle de B11 pour le suivi des SSC.
- Peu d'intérêt des certains ECZ .

# Annex 8

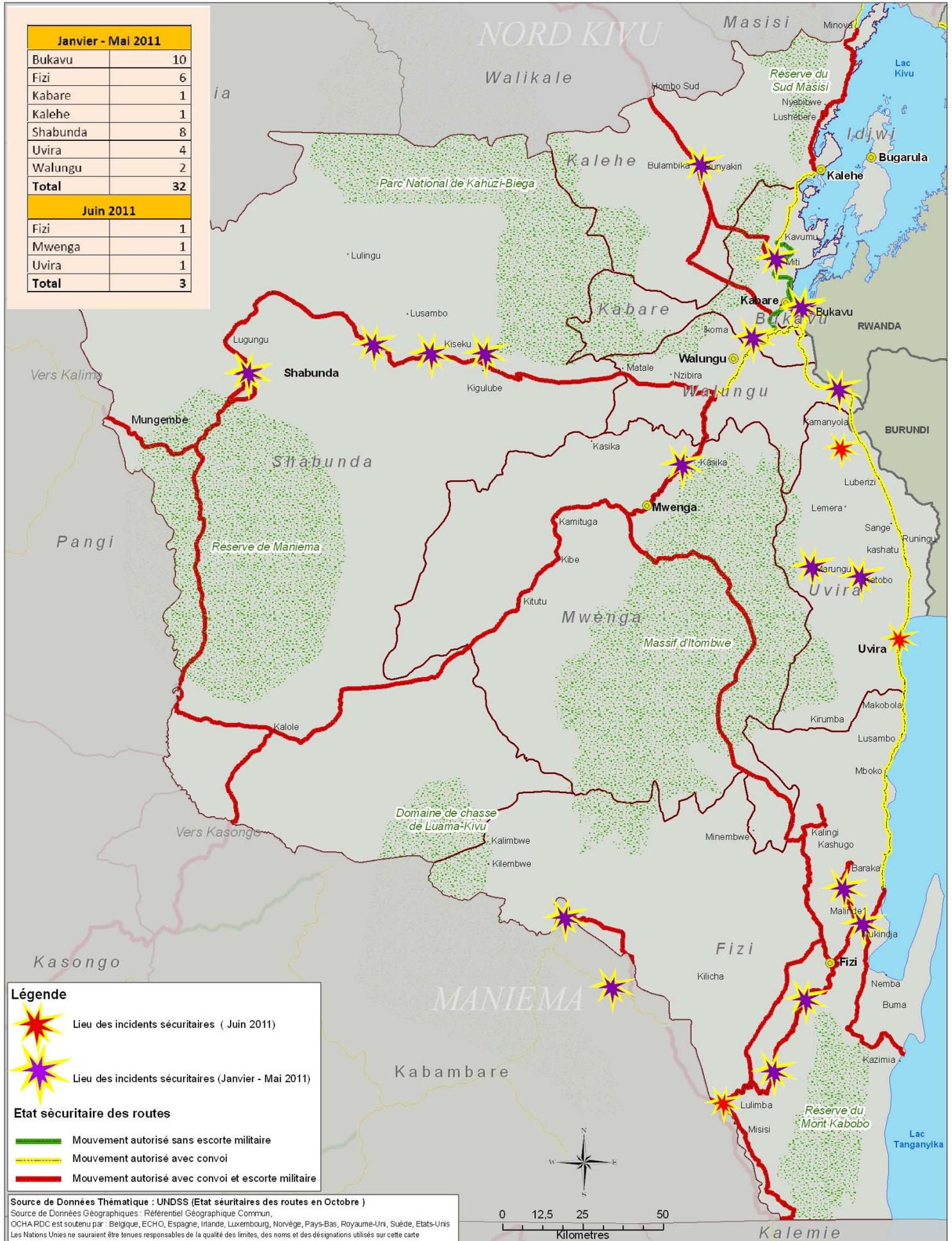


# Sud-Kivu: Incidents sécuritaires contre les humanitaires: Janvier - Juin 2011

Date de production: 12 Juillet 2011



Janvier - Mai 2011	
Bukavu	10
Fizi	6
Kabare	1
Kalehe	1
Shabunda	8
Uvira	4
Walungu	2
<b>Total</b>	<b>32</b>
Juin 2011	
Fizi	1
Mwenga	1
Uvira	1
<b>Total</b>	<b>3</b>



### Légende

-  Lieu des incidents sécuritaires ( Juin 2011)
-  Lieu des incidents sécuritaires (Janvier - Mai 2011)

### Etat sécuritaire des routes

-  Mouvement autorisé sans escorte militaire
-  Mouvement autorisé avec convoi
-  Mouvement autorisé avec convoi et escorte militaire

Source de Données Thématique : UNDSS (Etat sécuritaires des routes en Octobre )  
 Source de Données Géographiques : Répertoire Géographique Commun,  
 OCHA/RDC est soutenu par : Belgique, ECHO, Espagne, Irlande, Luxembourg, Norvège, Pays-Bas, Royaume-Uni, Suède, Etats-Unis  
 Les Nations Unies ne sauraient être tenues responsables de la qualité des limites, des noms et des désignations utilisés sur cette carte

# Annex 15

**Government of DRC**

**COP (key)**  
*Ousmane Faye*

**USAID/DRC**  
*Other CAs and donors*

**Senior Program Assistant**  
*Litho Shada Shaddah*

# Kinshasa Office (HQ)

**Senior Technical Advisor, Primary Health Care (Key)**  
*Gilbert Andrianandrasana*

**M&E Specialist (Key)**  
*Alidor Kuamba*

**F&A Specialist (Key)**  
*Lila Rabibisoa*

**Operations Manager**  
*Déo Gracias Makangu*

**DCOP (Key) - IRC**  
*Pascal Ngoy Leya*

**MNH /FP/RH Technical Advisor**  
*Colette Losso*

**Ops Research Technical Advisor**

**HR Manager**  
*Hypolite Ndjibu*

**IT Specialist**  
*Jonathan Kanza*

**Field Office Supervisor**  
*Leon Katambayi*

**CH Technical Advisor**  
*Narcisse Naia*

**Quality Assurance Advisor**

**HR Assistant**  
*Diogene Nshue*

**Logistic Assistants/Drivers (2)**  
*Dadou Molaka*

**Field Office Supervisor**  
*Britou Ndela*

**HIV/AIDS, TB, Malaria Technical Advisor**  
*Raoul Ngoy*

**Capacity Building Technical Advisor**  
*Kashosi Mujalambo*

**Finance Manager**

**Receptionist/ Administrative Assistant**  
*Etienne Ndiwulu*

**Commodities/Logistics Specialist**  
*Jeancy Mbuku*

**BCC Technical Advisor – OSC**  
*Jean Baptiste Mputu*

**Training Specialist**

**Senior Accountant**  
*Cecile Kambaya*

**Office Assistant**  
*Fifi Kabwiku*

**Gender/GBV Technical Advisor – IRC**  
*Bridget Lombardo*

**WASH Technical Advisor -IRC**  
*Simeon Kenfack*

**Accountant**  
*Jean Reddy Anke*

**Fleet, Travel, & Events Coordinator**  
*Alphonse Kanyengele*

**Renovation Expert (for PY2)**

**Health Finance Advisor**  
*Delmond Kyanza*

**Accounting Assistant**  
*Flory Dikala*

**Procurement & Facilities Coordinator**  
*Bijou Mbombo*

**Malaria Advisor**  
*John Otshudiema*

**Nutrition Advisor**  
*Matthieu Koy Matili*

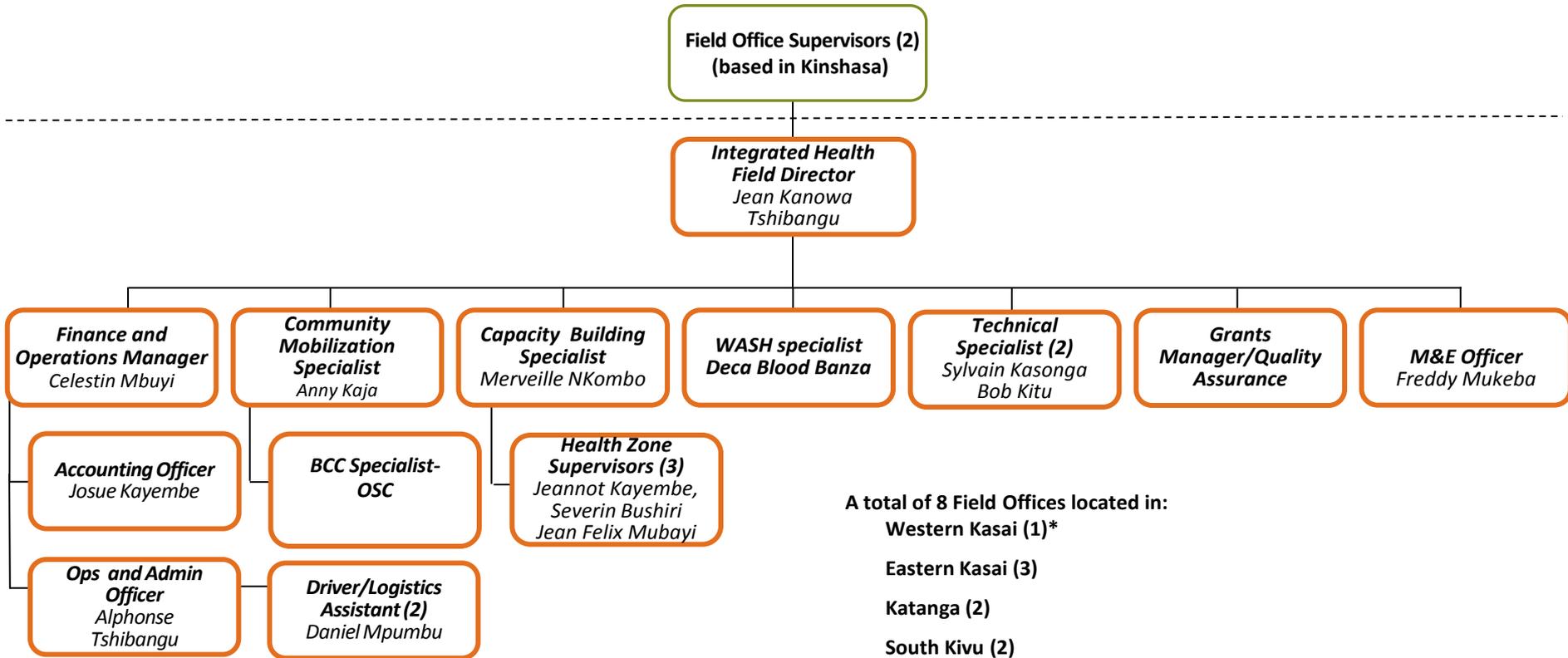
**Contracts/Grants & Compliance Manager**  
*Joel Amisi Mugeni*

**Maternal & Newborn Advisor**  
*Lucie Zikudieka*

**Compliance Analyst**

**Contracts/Grants Assistant**

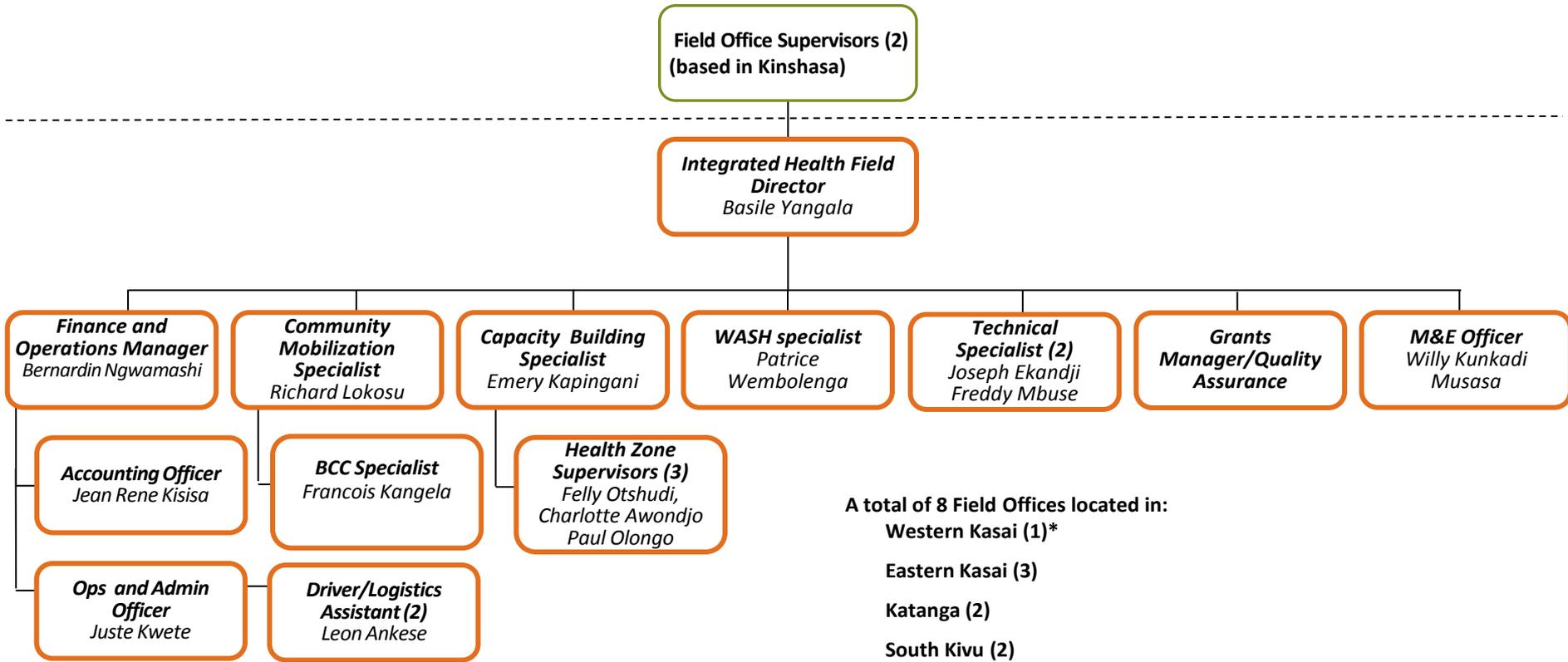
# IHP Field Office: Luiza, Western Kasai



A total of 8 Field Offices located in:  
Western Kasai (1)\*  
Eastern Kasai (3)  
Katanga (2)  
South Kivu (2)

\*Mwene Ditu office in Eastern Kasai will cover part of Western Kasai

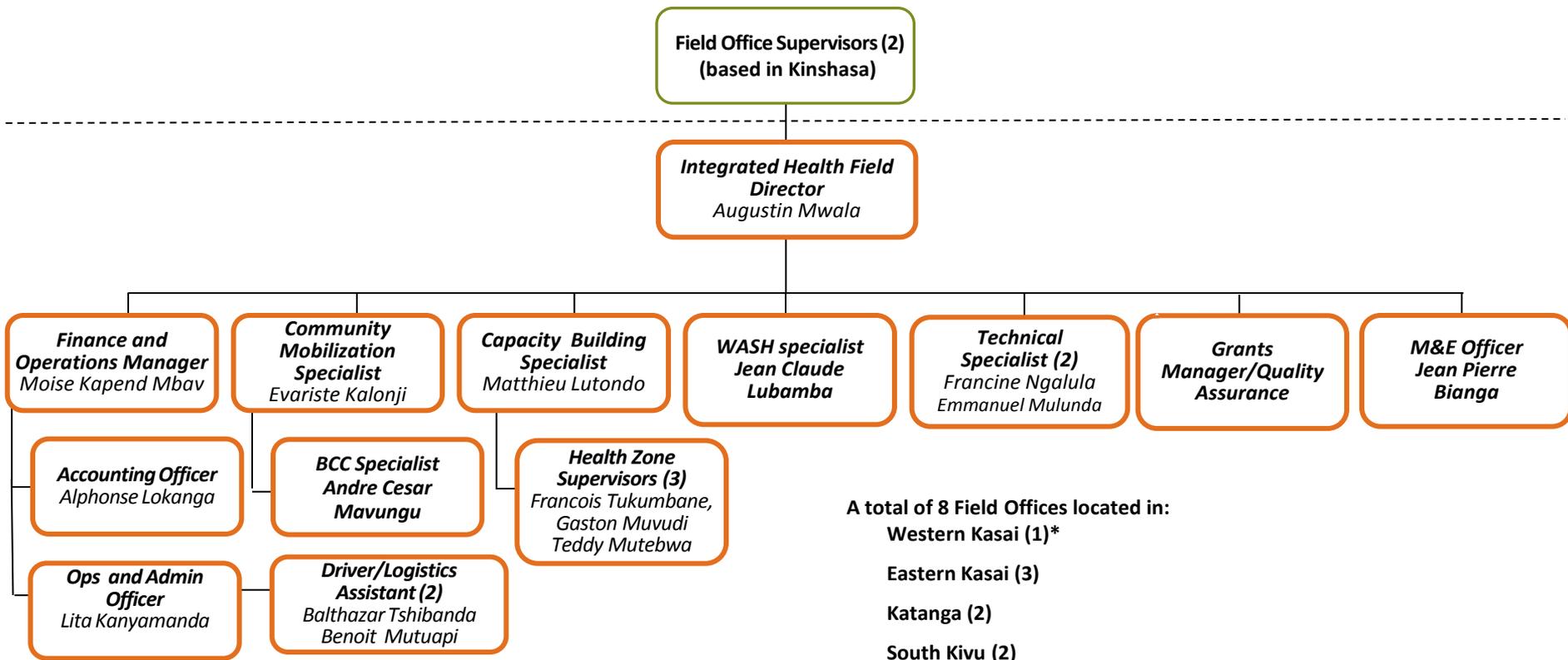
# IHP Field Office: Kole, Eastern Kasai



A total of 8 Field Offices located in:  
Western Kasai (1)\*  
Eastern Kasai (3)  
Katanga (2)  
South Kivu (2)

\*Mwene Ditu office in Eastern Kasai will cover part of Western Kasai

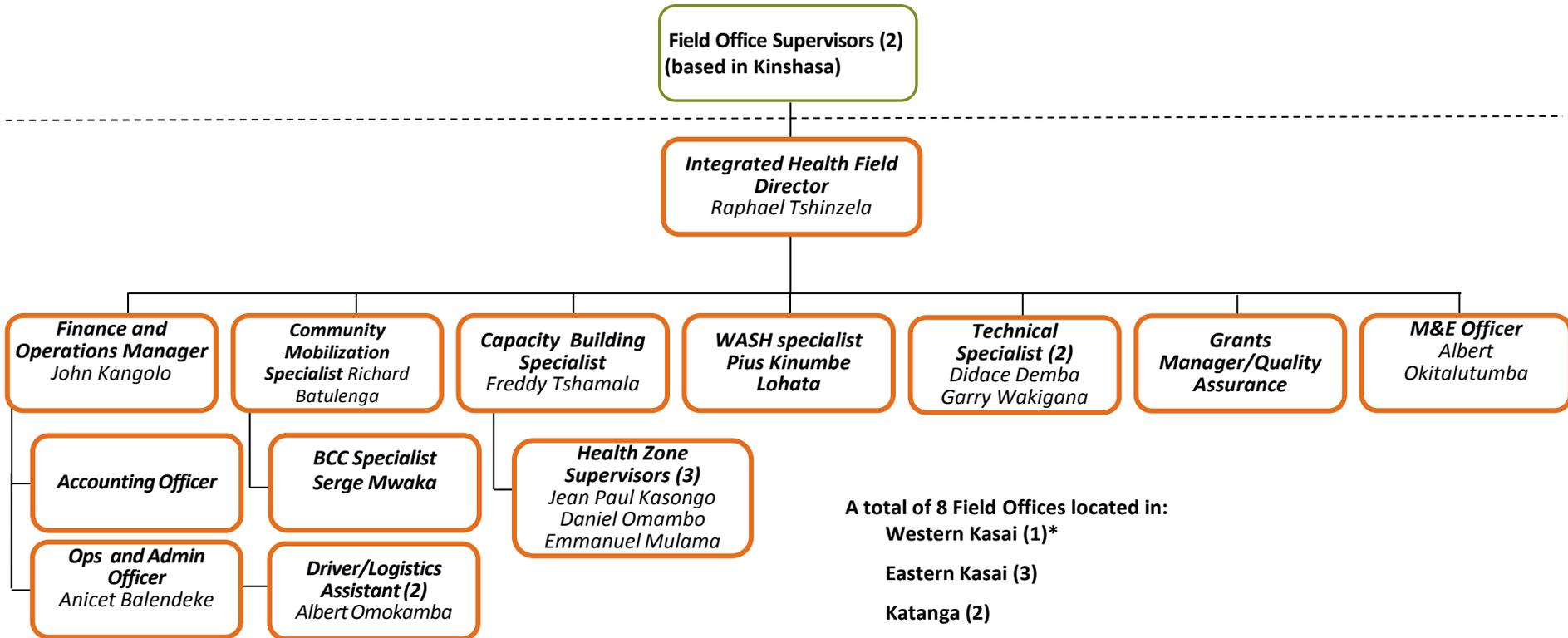
# IHP Field Office: Mwene-Ditu, Eastern Kasai



A total of 8 Field Offices located in:  
Western Kasai (1)\*  
Eastern Kasai (3)  
Katanga (2)  
South Kivu (2)

\*Mwene Ditu office in Eastern Kasai will cover part of Western Kasai

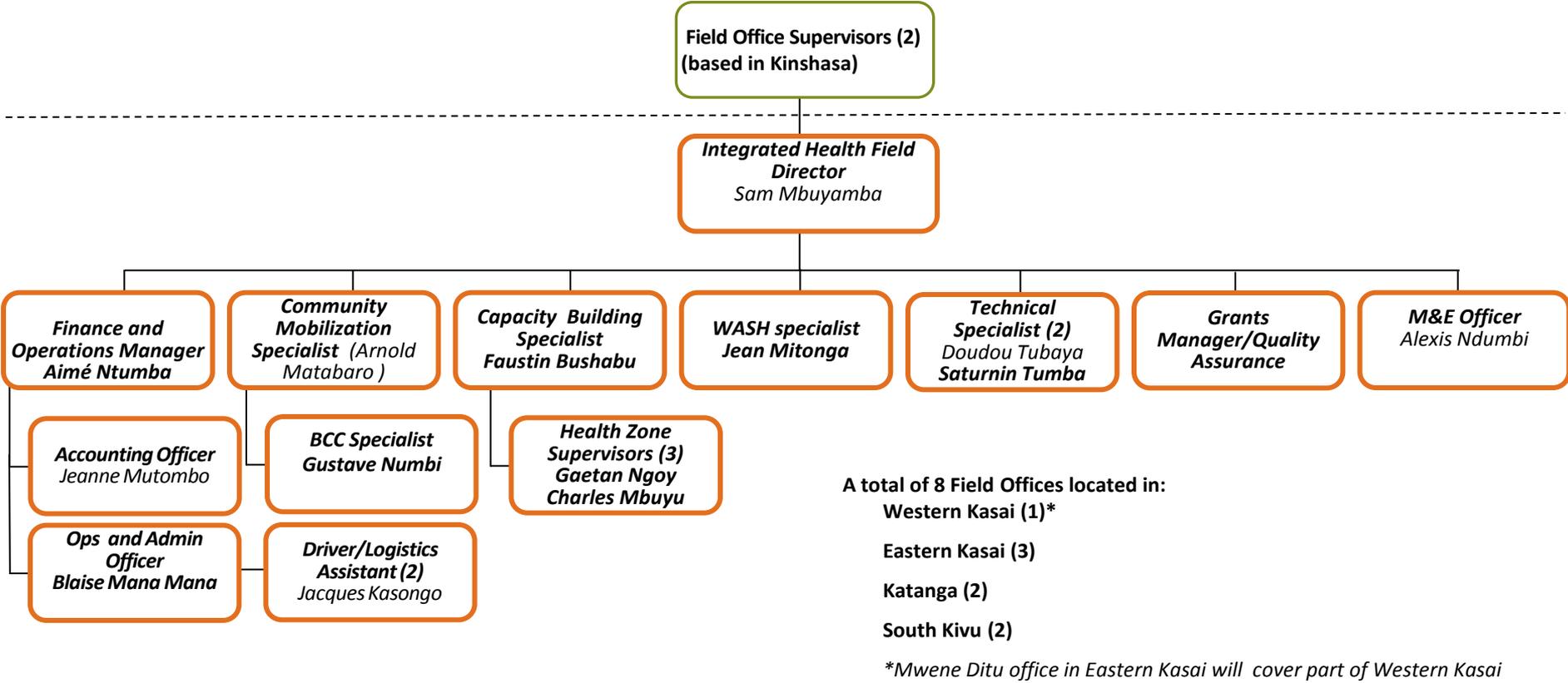
# IHP Field Office: Tshumbe, Eastern Kasai



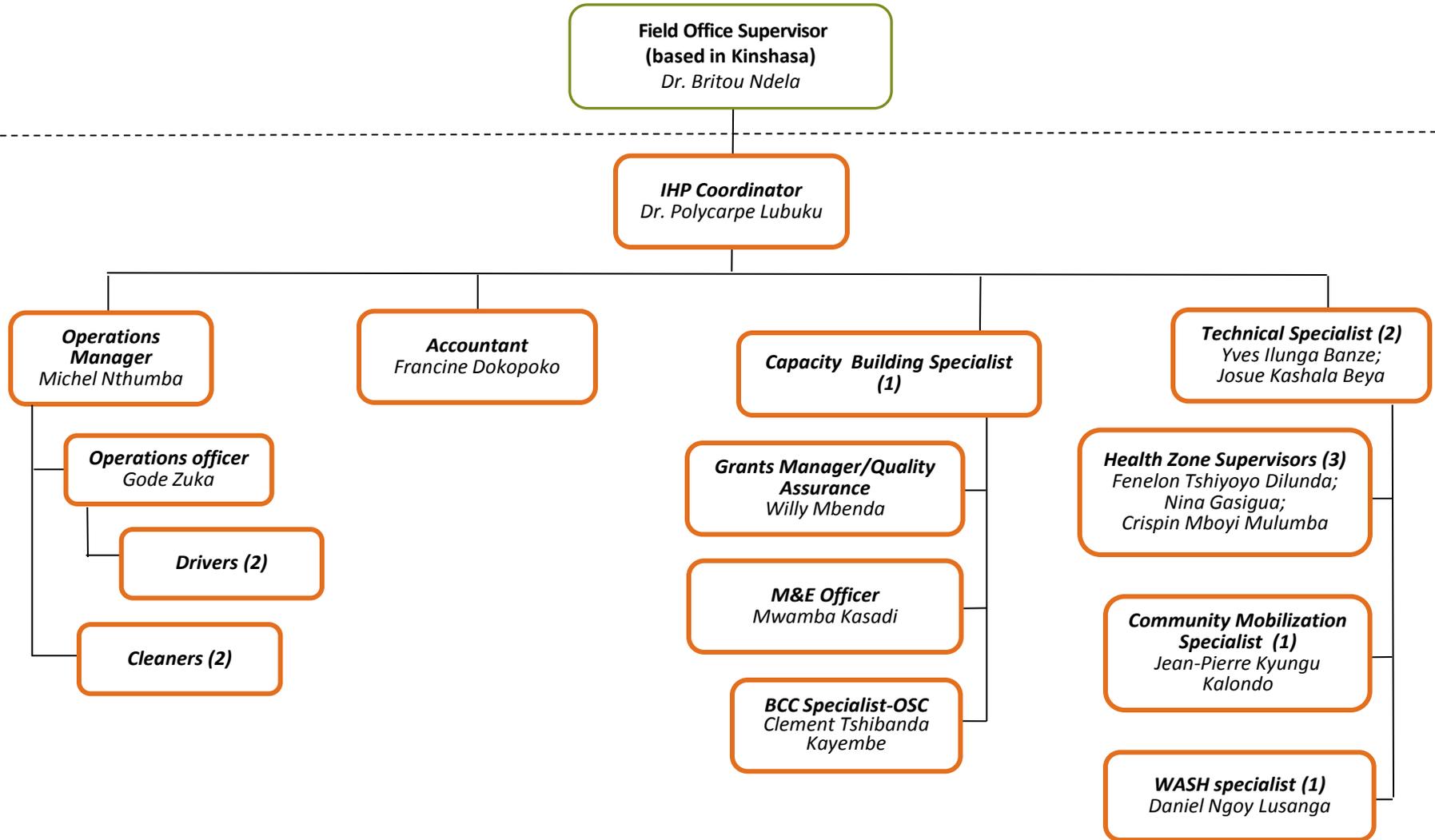
A total of 8 Field Offices located in:  
Western Kasai (1)\*  
Eastern Kasai (3)  
Katanga (2)  
South Kivu (2)

*\*Mwene Ditu office in Eastern Kasai will cover part of Western Kasai*

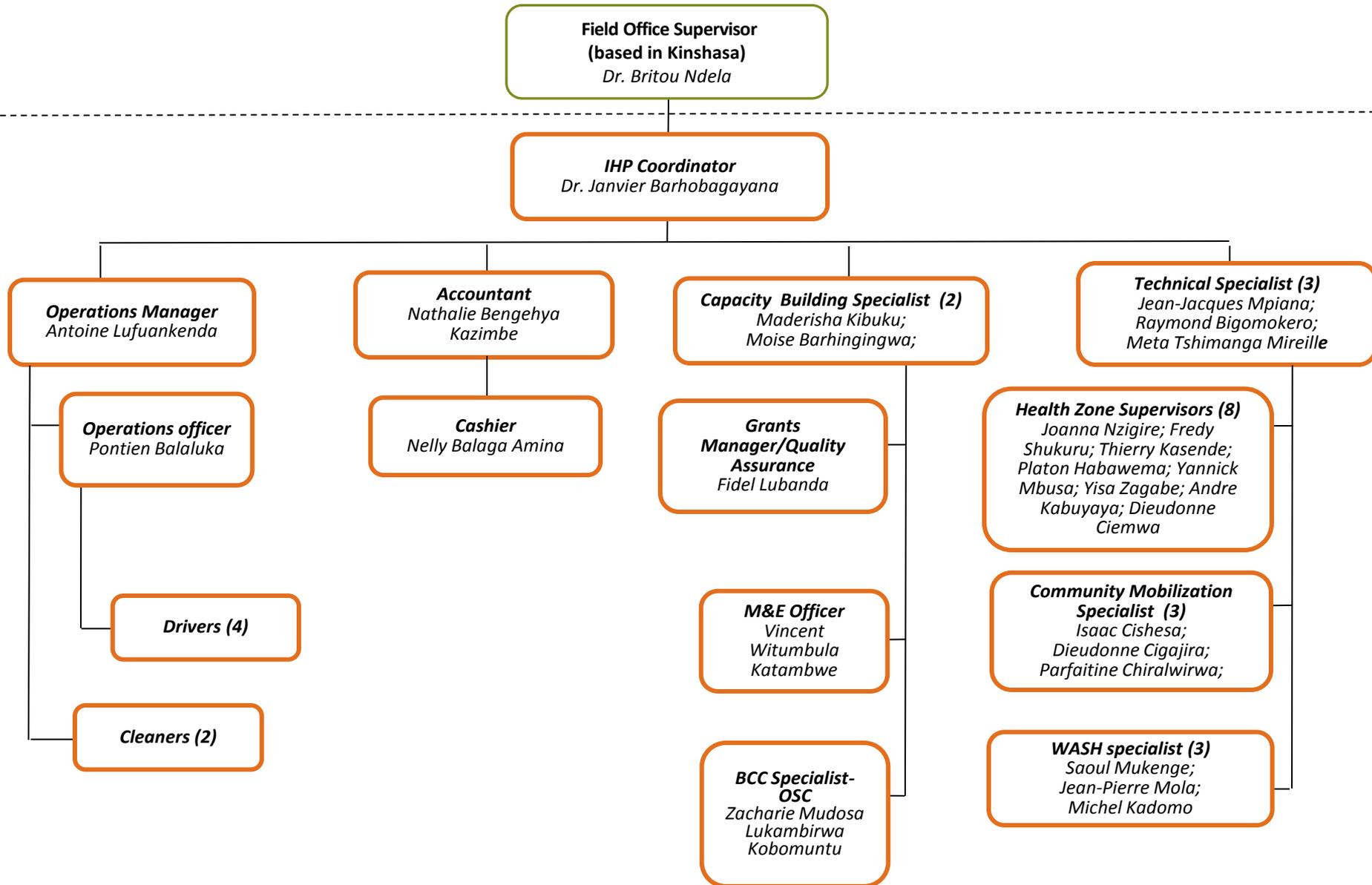
# IHP Field Office: Kamina, Katanga



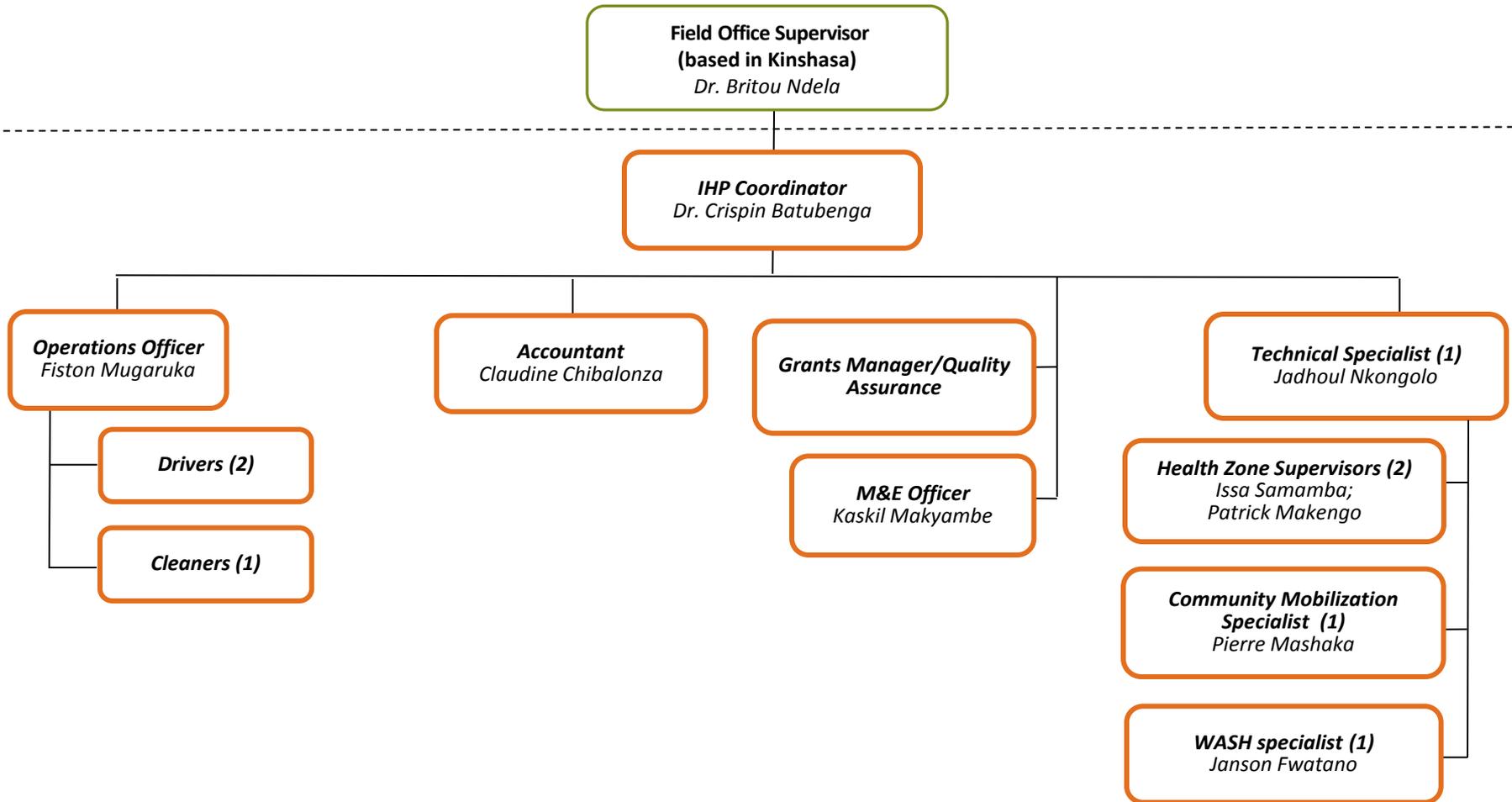
# IHP Field Office: Kolwezi (IRC)



# IHP Field Office: Bukavu (IRC)



# IHP Field Office: Uvira (IRC)



# Annex 16

**Integrated Health Project (IHP) Year 1 International Travel and STTA Plan Oct 2010-Sept 2011 (update 21 July 2011)**

#	TECHNICAL AREA	SUGGESTED PERSON	ORG	Travel dates	INDICATIVE SCOPE OF WORK	Origin/destination	length of trips	STATUS
						to	days	
<b>STTA/PROJECT MANAGEMENT AND MONITORING</b>								
<b>Quarter 1 Oct-Dec 2010</b>								
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	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	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 communications staff.	DC	11	Completed
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	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	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	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	18	Completed
8	Operations/Finance	Steve Morgan	MSH	Dec 08-Dec 22, 2010	Provide coverage for the Director of Finance and operations	Boston	12	Completed
<b>Quarter 2 Jan-Mar 2011</b>								
9	Team Orientation Workshop	John Pollock	MSH	Jan 01- Jan 15, 2011	Conduct team orientation Workshop/ Role & Clarification workshop	Boston	15	Completed
10	Recruitment	Felix Austine	MSH	Jan 04 - Feb 02, 2011	Continue the recruitment of new staff	Nigeria	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	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	15	Completed
15	BCC Assessment	Andrei Sinioukov	OSC	Feb 14-March 4, 2011	Conduct baseline KAP assessments for IHP target zones	Tanzania	19	Completed
16	BCC Assessment	Waverly Rennie	OSC	Feb 14-March 4, 2011	Conduct baseline KAP assessments for IHP target zones	Tanzania	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	Boston	20	Completed

					Human Resources Manager			
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	Completed
20	Project Management	Kristin Cooney	MSH	March 06- March 19, 2011	To provide technical support and guidance /reporting assistance	Boston	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	Completed
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	9	Completed
<b>Quarter 3 Apr-Jun 2011</b>								
24	SNIS	Nkossi Dambita	MSH	Apr 1 - Apr 16, 2011	Support PROSANI to strengthen MoH Système National de Information de la Santé (SNIS)	Maryland	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	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	14	Completed

27	Contract and Grant Management	Peter Mahoney	MSH	April 4 - April 15, 2011	Contracts/Grants Management; PBF contracting system; contractor/grantee monitoring system,	Boston	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	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	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	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 develop assessment tools for CODESAs	Peru	15	Postponed
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	Ongoing

Quarter 4 Jul-Sep 2011

35	BCC	Karin Veltman	OSC	Jul-11	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	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 return	40	Planned
37	WASH Consultant	TBC	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	TBC	40	July/August
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	16	Planned
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	14	Completed
40	Project Management and Technical Assistance	Kristin Cooney	MSH	July 10-23, 2011	To provide technical support and guidance /reporting	Boston	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	14	Planned

42	Nutrition Activity Planning and Technical Assistance	TBD	MSH	Aug 21-Sep 10, 2011	Train nutrition advisor; strengthen planning on nutrition interventions	TBD	16	Planning
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	27	Planned
44	BCC	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.	France	27	Planned
45	BCC/Community Champion Consultant	TBD	OSC	Sep 12 - Oct 21, 2011	To research and develop Community Champion (CC) approach, develop CC user manual, train field staff in the CC approach and use of the manual, and set up procedures and systems for media monitoring.		37	Planned
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	Baltimore	28	Planned

					field offices.			
47	Operations and workplanning for Year II	Christele Joseph-Pressat	MSH	Sep 25-Oct 8, 2011	Work with finance/admin team on budgeting workplan produced during workplanning workshop	Boston	16	Planning
48	Operations, workplanning Year II, and technical support	Joan Marshall-Missiye	MSH	Sep 18-Oct 8, 2011	Provide technical support during workplanning workshop; visit project sites	Boston	21	Planning
49	Workplanning Year 2 and Technical Assistance	Jean Kagubare	MSH	Sep 25-Oct 8, 2011	Provide technical support during workplanning workshop; visit project sites related to PBF	Boston	16	Planning

50	Project Management and Technical Assistance; Workplanning Year 2	Kristin Cooney	MSH	Sep 18-Oct 8, 2011	Provide technical support during workplanning workshop; visit project sites	Boston	21	Planning
51	PBF	TBD	MSH	Sep 01-Sep 15, 2011	To conduct cost and revenue analysis	Cambridge	16	Planning
52	Workplanning Year 2	Karin Veltman	OSC	Sep 20-Oct 7, 2011	Provide technical support during workplanning workshop	Philadelphia	17	Planning
53	Workplanning Year 2 and M&E Technical Assistance	Juan Carlos Alegre	MSH	Sep 25-Oct 8, 2011	Provide technical support during workplanning workshop; Training of M&E staff; visit project sites related to M&E system	Arlington	16	Planning
54	Commodity Security Technical Assistance	Tom Layloff	MSH	Sep 4-Sep 16, 2011	Provide technical assistance on quality assurance for essential medicines	Arlington	12	Planning
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	21	Planning

56	Commodity Security Technical Assistance	Ned Helzer	MSH	Sep 4-Sep 16, 2011	Provide technical assistance on quality assurance for essential medicines, procurement, and distribution	Arlington	12	Planning
INTERNATIONAL TRAVEL IHP LOCAL STAFF AND PARTNERS								
Quarter 1 Oct-Dec 2010								
N/A								
57								
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	April-11	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
62	WASH	Simeon Kenfack	IRC	May 28-June 3, 2011	Travel to / from IRC Global Health Conference - WASH Advisor	Kinshasa/Bangkok	7	Completed

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
<b>Quarter 4 Jul-Sep 2011</b>								
66	Gender / GBV	Bridget Lombardo	IRC	Jul-11	Travel to post for Gender / GBV Advisor	TBD	-	Completed
67	F&A	Lila Rabibisoa	MSH	Jul-11	R&R F&A Specialist	Paris/ Kinshasa return	15	Completed
68	COP	Ousmane Faye	MSH	Jul-11	R&R COP	Senegal/Kinshasareturn	15	Completed
69	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 action plans developed at meeting	Nairobi / Kinshasa return	6	Completed
70	WASH	Simeon Kenfack	Kinshasa/Douala Return	27-Aug-11	R&R WASH Advisor	Doula/Kinshasa return	14	Planned
71	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	Planned

72	Public Health	TBD	IRC	September 12- September 23, 2011	Travel to / from IRC Global Health Conference	Kinshasa / Bangkok	11	Planning
<p>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 07/21/1011)</p>								

**INVENTAIRE DU PATRIMOINE AXXES (COORDINATION IHP-KOLWEZI) au 30 juin 2011**

#	ZONE DE SANTE	DESCRIPTION DE L'EQUIPEMENT	DATE LA RECEPTION	RECIPIENDAIRE	DELIVRE A	QUANTITE	LIEU DE LOCALISATION	Qnte par localisation	No de SERIE	PRIX	CONDITIONS D'ACQUISITION			ETAT A L'INVENTAIRE		
											NEUF	FAIR	POUR	BON	MAUVAIS	
1	ZONE DE SANTE DE BUNKEYA	MOTO YAMAHA 125 DT + CASQUE	19 Avril 2007	WVL	KOL WEZI	1	BUNKEYA	1		\$ 3,445.00			X		X	
		MOTO YAMAHA 125 DT + CASQUE	19 Avril 2007	WVL	KOL WEZI	1	BUNKEYA	1		\$ 3,445.00			X		X	
		MOTO YAMAHA 125 DT + CASQUE	29. Janvier 2008	WVL	KOL WEZI	1	BUNKEYA	1		\$ 3,450.00			X		X	
		MOTO HONDA 125	2009	WVL	KOL WEZI	1	BUNKEYA	1							X	
		REFRIGERATEUR SIBIR 170 KE	12 Juillet 2007	WVL	KOL WEZI	0	BUNKEYA	0								
		TABLE OPERATION HYDRAULIQUE	12 Novembre 2007	WVL	KOL WEZI	0	BUNKEYA	0								
		GROUPE ELECTROGENE 2.3 Kva	19 Avril 2007	WVL	KOL WEZI	1	BUNKEYA	1		\$ 890.00			X		x	
		GROUPE ELECTROGENE 2.3 Kva	1 Fev 2008	WVL	KOL WEZI	1	BUNKEYA	1		\$ 890.00			X		x	
		STERILIZER+BASE	28Fevrier 2008	WVL	KOL WEZI	0	BUNKEYA	0								
		ORDINATEUR DELL:UNITE CENTRALE	10 Octobre 2007	WVL	KOL WEZI	0	BUNKEYA	0								
		DELL LAP TOP T7250	27-May-10	WVL	KOL	1	BUNKEYA	1		\$	x			x		

				WEZI		YA			830.00						
	FRIGO SOLAIRE SUNDANZER drc 165	30 Septembre 2008	WVL	KOL WEZI	0	BUNKE YA	0								
	FRIGO SOLAIRE SUNDANZER drc 165	05 Mai 2009	WVL	KOL WEZI	1	BUNKE YA	1		\$ 563.58		X		x		
									\$ 9,233.58						
2	ZONE DE SANTE LUALABA	MOTO HONDA 125	2009	WVL	KOL WEZI	1	LUALA BA	1						x	
		MOTO YAMAHA 125 DT + CASQUE (Yaer 2)	29. Janvier 2008	WVL	KOL WEZI	1	LUALA BA	1		\$ 3,450.00		X		x	
		MOTO YAMAHA 125 DT + CASQUE	19 Avril 2007	WVL	KOL WEZI	1	LUALA BA	1		\$ 3,445.00		X		x	
		MOTO YAMAHA 125 DT + CASQUE	19 Avril 2007	WVL	KOL WEZI	1	LUALA BA	1		\$ 3,445.00		X		x	
		MOTO YAMAHA 125 DT + CASQUE	19 Avril 2007	WVL	KOL WEZI	1	LUALA BA	1		\$ 3,445.00		X		x	
		TABLE OPERATION HYDRAULIQUE	12 Novembre 2007	WVL	KOL WEZI	0	LUALA BA	0							
		GROUPE ELECTROGENE 2.3 Kva	19 Avril 2007	WVL	KOL WEZI	1	LUALA BA	1		\$ 890.00		X		x	
		GROUPE ELECTROGENE 2.3 Kva	1 Fevrier 2008	WVL	KOL WEZI	0	LUALA BA	0		\$ 800.00					
		STERILIZER+BASE	28 Fevrier 2008	WVL	KOL WEZI	1	LUALA BA	1		\$ 693.45		X			
		ORDINATEUR DELL:UNITE CENTRALE	10 Octobre 2007	WVL	KOL WEZI	1	LUALA BA	1		\$ 599.00		X		x	
		FRIGO SOLAIRE SUNDANZER drc 165	12 Novembre	WVL	KOL WEZI	1	LUALA BA	1		\$ 563.58		X			

		2007												
		30 Septembr e 2008	WVL	KOL WEZI	0	LUALA BA	0							
		05 Mai 2009	WVL	KOL WEZI	1	LUALA BA	1		\$ 563.58		X			
		27-May-10	WVL	KOL WEZI	1	LUALA BA	1		\$ 830.00	x			x	
									\$ 17,894. 61					
	ZONE DE SANTE DILALA	29. Janvier 2008	WVL	KOL WEZI	1	DILALA	1		\$ 3,450.00			X		x
		19 Avril 2007	WVL	KOL WEZI	1	DILALA	1		\$ 3,445.00			X		x
		19 Avril 2007	WVL	KOL WEZI	1	DILALA	1		\$ 3,445.00			X		x
		2009	WVL	KOL WEZI	1	DILALA	1							x
		12 Juillet 2007	WVL	KOL WEZI	0	DILALA	0		\$ 2,186.00					
		12 Novembre 2007	WVL	KOL WEZI	0	DILALA	0		\$ 1,692.50					
		19 Avril 2007	WVL	KOL WEZI	1	DILALA	1		\$ 890.00			X		
		28 Fevrier 2008	WVL	KOL WEZI	1	DILALA	1		\$ 693.45		X			
		10 Octobre 2007	WVL	KOL WEZI	1	DILALA	1		\$ 599.00			X		x
		27-May-10	WVL	KOL WEZI	1	DILALA	1		\$ 830.00	x				x



		e 2008												
		FRIGO SOLAIRE SUNDANZER drc 165	05 Mai 2009	WVL	KOL WEZI	1	FUNGU RUME	1		\$ 563.58		X		
										\$ 16,271. 08				
5	ZONE DE SANTE DE LUBUDI	MOTO YAMAHA 125 DT + CASQUE	19 Avril 2007	WVL	KOL WEZI	1	LUBUDI	1		\$ 4,150.00	X			x
		MOTO YAMAHA 125 DT + CASQUE (Yaer 2)	29. Janvier 2008	WVL	KOL WEZI	1	LUBUDI	1		\$ 3,450.00		X		x
		MOTO YAMAHA 125 DT + CASQUE	19 Avril 2007	WVL	KOL WEZI	1	LUBUDI	1						x
		MOTO YAMAHA 125 DT + CASQUE	19 Avril 2007	WVL	KOL WEZI	1	LUBUDI	1						x
		MOTO HONDA 125	2009	WVL	KOL WEZI	1	LUBUDI	1						x
		MOTO HONDA 126	2010	WVL	KOL WEZI	1	LUBUDI	1						x
		REFRIGERATEUR SIBIR 170 KE	06-Jul-07	WVL	KOL WEZI	0	LUBUDI	0		\$ 2,186.00		x		
		TABLE OPERATION HYDRAULIQUE	12 Novembre 2007	WVL	KOL WEZI	0	LUBUDI	0						
		ORDINATEUR DELL:UNITE CENTRALE	10 Octobre 2007	WVL	KOL WEZI	1	LUBUDI	1						x
		DELL LAP TOP T7250	27-May-10	WVL	KOL WEZI	1	LUBUDI	1		\$ 830.00	x			x
		GROUPE ELECTROGENE 2.3 Kva	19 Avril 2007	WVL		0	LUBUDI	0						
		GROUPE ELECTROGENE 2.3 Kva	1 Fev2008	WVL	KOL WEZI	1	LUBUDI	1						x
		FRIGO SOLAIRE	12	WVL	KOL	1	LUBUDI	1		\$		X		

		SUNDANZER drc 165	Novembre 2007		WEZI				563.58						
		FRIGO SOLAIRE SUNDANZER drc 165	30 Septembre 2008	WVL	KOL WEZI	1	LUBUDI	1	\$ 563.58		X				
		FRIGO SOLAIRE SUNDANZER drc 165	05 Mai 2009	WVL	KOL WEZI	2	LUBUDI	2	\$ 563.58		X				
									\$ 11,476.74						
6	ZONE DE SANTE DE MUTSHATSHA	MOTO YAMAHA 125 DT + CASQUE	19 Avril 2007	WV	KOL WEZI	1	MUTSH ATSHA	1	\$ 3,445.00			X		x	
		MOTO YAMAHA 125 DT + CASQUE	19 Avril 2007	WV	KOL WEZI	1	MUTSH ATSHA	1	\$ 3,445.00			X		x	
		MOTO YAMAHA 125 DT + CASQUE	19 Avril 2007	WV	KOL WEZI	1	MUTSH ATSHA	1	\$ 3,445.00			X		x	
		MOTO HONDA 125	2009	WVL	KOL WEZI	1	MUTSH ATSHA	1						x	
		MOTO HONDA 126	2010	WVL	KOL WEZI	1	MUTSH ATSHA	1					x		
		ORDINATEUR DELL:UNITE CENTRALE	10 Octobre 2007	WVL	KOL WEZI	1	LUBUDI	1						x	
		DELL LAP TOP T7250	27-May-10	WVL	KOL WEZI	1	BUNKE YA	1						x	
		REFRIGERATEUR SIBIR 170 KE	12 Juillet 2007	WVL	KOL WEZI	0	MUTSH ATSHA	0							
		TABLE OPERATION HYDRAULIQUE	12 Novembre 2007	WVL	KOL WEZI	0	MUTSH ATSHA	0							
		GROUPE ELECTROGENE 2.3 Kva	19 Avril 2007	WVL	KOL WEZI	1	MUTSH ATSHA	1		\$ 890.00			X		x
		STERILIZER+BASE	28 Fevrier	WVL	KOL	0	MUTSH	0							

		2008		WEZI		ATSHA								
	FRIGO SOLAIRE SUNDANZER drc 165	30 Septembre 2008	WVL	KOL WEZI	0	MUTSH ATSHA	0							
	FRIGO SOLAIRE SUNDANZER drc 165	05 Mai 2009	WVL	KOL WEZI	1	MUTSH ATSHA	1		\$ 563.58		X			
									\$ 11,788.58					
7	ZONE DE SANTE DE KANZENZE	MOTO YAMAHA 125 DT + CASQUE	19 Avril 2007	WVL	KOL WEZI	1	KANZE ZE	1	\$ 3,445.00			X		x
		MOTO YAMAHA 125 DT + CASQUE	19 Avril 2007	WVL	KOL WEZI	1	KANZE ZE	2	\$ 3,445.00			X		x
		MOTO YAMAHA 125 DT + CASQUE	19 Avril 2007	WVL	KOL WEZI	1	KANZE ZE	2	\$ 3,445.00			X		x
		MOTO YAMAHA 125 DT + CASQUE (Yaer 2)	29. Janvier 2008	WVL	KOL WEZI	1	KANZE ZE							x
		MOTO HONDA 125	2009	WVL	KOL WEZI	1	KANZE ZE	1						x
		REFRIGERATEUR SIBIR 170 KE	06-Jul-07	WVL	KOL WEZI	0	KANZE ZE	0						
		TABLE OPERATION HYDRAULIQUE	12 Novembre 2007	WVL	KOL WEZI	0	KANZE ZE	0						
		GROUPE ELECTROGENE 2.3 Kva	19 Avril 2007	WVL	KOL WEZI	0	KANZE ZE	0						x
		STERILIZER+BASE	28 Fevrier 2008	WVL	KOL WEZI	1	KANZE ZE	1	\$ 693.45			X		
		ORDINATEUR DELL:UNITE CENTRALE	10 Octobre 2007	WVL	KOL WEZI	1	KANZE ZE	1	\$ 599.00			X		x
	DELL LAP TOP T7250	27-May-10	WVL	KOL WEZI	1	BUNKE YA	1					x		

	FRIGO SOLAIRE SUNDANZER drc 165	12-Nov-07	WVL	KOL WEZI	1	KANZE ZE	1		\$ 563.58		X				
	FRIGO SOLAIRE SUNDANZER drc 165	05 Mai 2009	WVL	KOL WEZI	1	KANZE ZE	1		\$ 563.58		X				
									\$ 12,754.6 1						
8	ZONE DE SANTE DE MANIKA	MOTO YAMAHA 125 DT + CASQUE	19 Avril 2007	WVL	KOL WEZI	1	MANIK A	1	\$ 3,445.00			X		x	
		MOTO YAMAHA 125 DT + CASQUE	19 Avril 2007	WVL	KOL WEZI	1	MANIK A	2	\$ 3,445.00			X		x	
		MOTO YAMAHA 125 DT + CASQUE	19 Avril 2007	WVL	KOL WEZI	1	MANIK A	1	\$ 3,445.00			X		x	
		MOTO YAMAHA 125 DT + CASQUE (Yaer 2)	29. Janvier 2008	WVL	KOL WEZI	1	MANIK A	1						x	
		MOTO HONDA 125	2009	WVL	KOL WEZI	1	MANIK A	1						x	
		REFRIGERATEUR SIBIR 170 KE	12 Juillet 2007	WVL	KOL WEZI	2	MANIK A	1	\$ 2,186.00			x			
		TABLE OPERATION HYDRAULIQUE	12 Novembre 2007	WVL	KOL WEZI	1	MANIK A	1	\$ 1,692.50			x			
		GROUPE ELECTROGENE 2.3 Kva	19 Avril 2007	WVL	KOL WEZI	0	MANIK A	0							
		STERILIZER+BASE	28 Fevrier 2008	WVL	KOL WEZI	0	MANIK A	0							
		ORDINATEUR DELL:UNITE CENTRALE	10 Octobre 2007	WVL	KOL WEZI	1	MANIK A	1	\$ 599.00				X		x
		DELL LAP TOP T7250	27-May-10	WVL	KOL WEZI	1	MANIK A	1							x
		FRIGO SOLAIRE SUNDANZER drc 165	30 Septembr	WVL	KOL WEZI	0	MANIK A	0				X			

		e 2008												
		FRIGO SOLAIRE SUNDANZER drc 165	05 Mai 2009	WVL	KOL WEZI	1	MANIK A	1		\$ 563.58		X		
										\$ 15,376.0 8				
9	DISTRICT KOLWEZI	MOTO YAMAHA 125 DT + CASQUE	11 Juillet 2007	WVL	KOL WEZI	1	kolwezi	1	DE02X- 037562	\$ 3,230.00			X	
		GROUPE ELECTROGENE 2.3 Kva	11 Juillet 2007	WVL	KOL WEZI	1	kolwezi	1	368913	\$ 800.00		X		
		ORDINATEUR, ECRAN PLAT OPTIPLEX	28 Fevrier 2008	WVL	KOL WEZI	1	kolwezi	1		\$ 649.00			X	
									\$ 4,679.0 0					
<b>TOTAL GENERAL</b>										\$ 116,438. 81				

# Annex 10

No	zones de santé	Materiels /Engins disponibles dans la zone	ETAT		Materiels/Engins repris sur la liste Axxes	Materiels/Engins Axxes recus dans la ZS	ETAT		OBSERVATIONS
			BE	ME			BE	ME	
I	<b>SHABUNDA</b> Population Totale: <b>162616</b>  Habitants.	10 Motos	4	6	<b>2 Moto DT 125 :</b> DEX013920, DE02X055438	<b>5 Motos DT 125 :</b> 3TT-155437,3TT-155947,3TT-171780,3TT7472,3TT-185621	3	2	<b>La panne de cylindre complet et carburateur et le systeme de transmission , au total la ZS a 10 Moto don't 4 en BE et 6 ME</b>
		vehicule Land Cruiser	x		1 Lap top Ultrasound 1407		1 Refrigerateur ELECTROLUX	X	
		1 Refrigerateur ELECTROLUX	X		2 refrigerateurs SIBIR 170EK	2 Refrigerateurs SIBIR	X		
		2 Tables operatoire hydraulique	x			7 Sterilisateurs	x		

II	<u>KALOLE</u>	6 Motos	4	2	2 Moto DT 125 : DE02X58680, DE02X058623	5 Motos DT	3	2	<b>NB:</b> La ZS a 6 Motos dont 4 en BE et 1 moto en ME , parmi les 4 motos en BE 1 Moto a été affecte a l' HGR , aussi il faut noter les 2 motos dotees par Merlin / AXxes ont brulees par les militaires FDLR .
		1 Refrigerateurs Sibir		x	<b>1Lap top Ultrasound 1417</b>	1 Refrigerateurs Sibir		x	<b>Insuffisance des carburants pour la supervision</b>
		2 Refrigerateurs Solaire	x		<b>2 Refrigerateurs</b>	2 Refrigerateurs Solaire	x		
	2 Sterilisateur electrique	x		<b>1 Sterilisateur + base</b>	2 Sterilisateur electrique	x			
	1 Laptop	X			9 Panneaux solaires	6	3		
	Population Totale:103907 Habitants.								
III	<u>LULINGU</u>	10 Motos yamaha 125	3	7	1 Refrigerateur Sibir	<b>1 Moto yamaha DT 125</b>	x		<b>NB:</b> au total la zone de sante a au total 10 Motos dont 3 sont en bon etat entre autre 1 Moto d'Axxes fonctionnel

<b>Population Totale</b> <b>143 413</b> <b>Habitants.</b>	1 Réfrigérateurs Sibir	x		1 Réfrigérateurs Solaire Sundanzer	1 Réfrigérateurs Sibir	x		<b>problemes d'entretien et reparations des petites pannes,</b>
	1 Kit Desktop complet		x	1 ordinateur Dell + unite central	1 Kit Desktop complet		x	
	5 Panneaux solaire	4	1		5 Panneaux solaire	4	1	
	7 Batteries	x		<b>NB: la table d'opération hydraulique non vue dans la ZS</b>	7 Batteries	x		
	4 Tables Gynecologiques	x			4 Tables Gynecologiques	x		
		x		Axxes a donne 1 MOTO a la ZS , cette Moto est non reprise dans la liste Axxes	5 Velo Kinga	2	3	
		x			5 Kits New Born	x		
		?			1 Charging System	x		
					30 Lits d'hospitalisation	x		
					1 Table d'operation Hydraulique	?		
							<b>NB: La Zone de sante a 1 vehicule land Cruiser .</b>	

## Annex 11

### INVENTAIRE DU PATRIMOINE AXES (COORDINATION IHP-UVIRA)

#	ZONES DE SANTE	DESCRIPTION DE L'EQUIPEMENT	DATE LA RECEPTION	RECIPIEN DAIRE	DELIVRE A	QUANTITE	LIEU DE LOCALISATION	Qnte par localisation	No de SERIE	PRIX (USD)	CONDITIONS D'ACQUISITION			ETAT A L'INVENTAIRE	
											NEW	FAIR	POOR	BON	MAUVAIS
1	ZONE DE SANTE DE RUZIZI	MOTO YAMAHA 125 DT + CASQUE	19 Avril 2007	CRS/Buka vu	BUKA VU	1	RUZIZI	1	DE02X-027343	3,445.00			X		
		MOTO YAMAHA 125 DT + CASQUE	19 Avril 2007	CRS/Buka vu	BUKA VU	1	RUZIZI	2	DE02X-027358	3,445.00			X		
		MOTO YAMAHA 125 DT + CASQUE	19 Avril 2007	CRS/Buka vu	BUKA VU	1	RUZIZI	2	DE02X-027361	3,445.00			X		
		REFRIGERATEUR SIBIR 170 KE	12 Juillet 2007	CRS	BUKA VU	2	RUZIZI	2		2,186.00		x			
		TABLE OPERATION HYDRAULIQUE	12 Novembre 2007	CRS	BUKA VU	1	RUZIZI	1		1,692.50		x			
		GROUPE ELECTROGENE 2.3 Kva	19 Avril 2007	CRS/Buka vu	BUKA VU	1	RUZIZI	1	3666859	890.00			X		
		STERILIZER+BASE	28 Fevrier 2008	CRS/Buka vu	BUKA VU	1	RUZIZI	1		693.45		X			
		ORDINATEUR	10 Octobre	CRS/Buka	BUKA	1	RUZIZI	1						X	

	DELL:UNITE CENTRALE	2007	vu	VU					599.00					
	FRIGO SOLAIRE SUNDANZER drc 165	30 Septembre 2008	CRS	BUKA VU	1	RUZIZI	1		563.58		X			
	FRIGO SOLAIRE SUNDANZER drc 165	05 Mai 2009	CRS	BUKA VU	2	RUZIZI	2		563.58		X			
									<b>17,52 3.11</b>					
I	ZONE DE SANTE D'UVIRA	ULTRASOUND+LAPTOP SET	21. Sept. 2008	COP	KINSH ASA	1	UVIRA	1	1412	5,098. 00		X		
		MOTO YAMAHA 125 DT + CASQUE (Yaer 2)	29. Janvier 2008	CRS	BUKA VU	1	UVIRA	1	DE02X- 043889	3,450. 00			X	
		MOTO YAMAHA 125 DT + CASQUE	19 Avril 2007	CRS/Buka vu	BUKA VU	1	UVIRA	1	DE02X- 026829	3,445. 00			X	
		MOTO YAMAHA 125 DT + CASQUE	19 Avril 2007	CRS/Buka vu	BUKA VU	1	UVIRA	1	DE02X- 025623	3,445. 00			X	
		MOTO YAMAHA 125 DT + CASQUE	19 Avril 2007	CRS/Buka vu	BUKA VU	1	UVIRA	1	DE02X- 032696	3,445. 00			X	
		MOTO YAMAHA 125 DT + CASQUE	19 Avril 2007	CRS/Buka vu	BUKA VU	1	UVIRA	1	DE02X- 032690	3,445. 00			X	
		REFRIGERATEUR SIBIR 170 KE	12 Juillet 2007	CRS	BUKA VU	3	UVIRA	3		2,186. 00		x		
		TABLE OPERATION HYDRAULIQUE	12 Novembre 2007	CRS	BUKA VU	1	UVIRA	1		1,692. 50		x		

		GROUPE ELECTROGENE 2.3 Kva	19 Avril 2007	CRS/Buka vu	BUKA VU	1	UVIRA	1	366677 0	890.00			X		
		GROUPE ELECTROGENE 2.3 Kva	1 Fevrier 2008	CRS	BUKA VU	1	UVIRA	1		800.00		X			
		STERILIZER+BASE	28 Fevrier 2008	CRS/Buka vu	BUKA VU	1	UVIRA	1		693.45		X			
		ORDINATEUR DELL:UNITE CENTRALE	10 Octobre 2007	CRS/Buka vu	BUKA VU	1	UVIRA	1		599.00			X		
		FRIGO SOLAIRE SUNDANZER drc 165	12 Novembre 2007	CRS	BUKA VU	1	UVIRA	1		563.58		X			
		FRIGO SOLAIRE SUNDANZER drc 165	30 Septembre 2008	CRS	BUKA VU	2	UVIRA	2		563.58		X			
		FRIGO SOLAIRE SUNDANZER drc 165	05 Mai 2009	CRS	BUKA VU	1	UVIRA	1		563.58		X			
									<b>30,87 9.69</b>						
<b>3</b>	<b>ZONE DE SANTE NUNDU</b>	MOTO YAMAHA 125 DT + CASQUE	10.Juin .2010	CRS	BUKA VU	1	NUNDU	1	DE02X_058 689	4,150.00	X				
		MOTO YAMAHA 125 DT + CASQUE (Yaer 2)	29. Janvier 2008	CRS	BUKA VU	1	NUNDU	1	DE02X-043860	3,450.00			X		
		MOTO YAMAHA 125 DT + CASQUE	19 Avril 2007	CRS/Buka vu	BUKA VU	1	NUNDU	1	DE02X-025848	3,445.00			X		
		MOTO YAMAHA 125 DT + CASQUE	19 Avril 2007	CRS/Buka vu	BUKA VU	1	NUNDU	1	DE02X-031728	3,445.00			X		
		REFRIGERATEUR SIBIR 170 KE	12 Juillet 2007	CRS	BUKA VU	2	NUNDU	2		2,186.00		x			

		TABLE OPERATION HYDRAULIQUE	12 Novembre 2007	CRS	BUKA VU	1	NUNDU	1		1,692.50		x		
		GROUPE ELECTROGENE 2.3 Kva	19 Avril 2007	CRS/Buka vu	BUKA VU	1	NUNDU	1	3666772	890.00			X	
		STERILIZER+BASE	28 Fevrier 2008	CRS/Buka vu	BUKA VU	1	NUNDU	1		693.45		X		
		ORDINATEUR DELL:UNITE CENTRALE	10 Octobre 2007	CRS/Buka vu	BUKA VU	1	NUNDU	1		599.00			X	
		FRIGO SOLAIRE SUNDANZER drc 165	12 Novembre 2007	CRS	BUKA VU	1	NUNDU	1		563.58		X		
		FRIGO SOLAIRE SUNDANZER drc 165	30 Septembre 2008	CRS	BUKA VU	1	NUNDU	1		563.58		X		
		FRIGO SOLAIRE SUNDANZER drc 165	05 Mai 2009	CRS	BUKA VU	1	NUNDU	1		563.58		X		
										<b>22,241.69</b>				
<b>4</b>	<b>ZONE DE SANTE DE LEMERA</b>	MOTO YAMAHA 125 DT + CASQUE (Yaer 2)	29. Janvier 2008	CRS	BUKA VU	1	LEMERA	1	DE02X-043882	3,450.00			X	
		MOTO YAMAHA 125 DT + CASQUE (Yaer 2)	29. Janvier 2008	CRS	BUKA VU	1	LEMERA	1	DE02X-043941	3,450.00			X	
		MOTO YAMAHA 125 DT + CASQUE	19 Avril 2007	CRS/Buka vu	BUKA VU	1	LEMERA	1	DE02X-027496	3,445.00			X	
		MOTO YAMAHA 125 DT + CASQUE	19 Avril 2007	CRS/Buka vu	BUKA VU	1	LEMERA	1	DE02X-028915	3,445.00			X	

	REFRIGERATEUR SIBIR 170 KE	12 Juillet 2007	CRS	BUKA VU	1	LEMER A	1		2,186. 00		x			
	TABLE OPERATION HYDRAULIQUE	12 Novembre 2007	CRS	BUKA VU	1	LEMER A	1		1,692. 50		x			
	GROUPE ELECTROGENE 2.3 Kva	19 Avril 2007	CRS/Buka vu	BUKA VU	1	LEMER A	1	366678 4	890.00			X		
	ORDINATEUR DELL:UNITE CENTRALE	10 Octobre 2007	CRS/Buka vu	BUKA VU	1	LEMER A	1		599.00			X		
	FRIGO SOLAIRE SUNDANZER drc 165	30 Septembre 2008	CRS	BUKA VU	1	LEMER A	1		563.58		X			
	FRIGO SOLAIRE SUNDANZER drc 165	05 Mai 2009	CRS	BUKA VU	1	LEMER A	1		563.58		X			
								<b>20,28 4.66</b>						
<b>5</b>	<b>ZONE DE SANTE DES HAUX PLATEAUX</b>	MOTO YAMAHA 125 DT + CASQUE	10.Juin .2010	CRS	BUKA VU	1	BIJOMB O/HPU	1	DE02X_ 058 477	4,150. 00	X			
		REFRIGERATEUR SIBIR 170 KE	12 Juillet 2007	CRS	BUKA VU	2	BIJOMB O/HPU	2		2,186. 00		x		
		TABLE OPERATION HYDRAULIQUE	12 Novembre 2007	CRS	BUKA VU	1	BIJOMB O/HPU	1		1,692. 50		x		
		GROUPE ELECTROGENE 2.3 Kva	19 Avril 2007	CRS/Buka vu	BUKA VU	1	BIJOMB O/HPU	1	366689 3	890.00			X	
		FRIGO SOLAIRE SUNDANZER drc 165	12 Novembre 2007	CRS	BUKA VU	1	BIJOMB O/HPU	1		563.58		X		

		FRIGO SOLAIRE SUNDANZER drc 165	30 Septembre 2008	CRS	BUKA VU	1	BIJOMB O/HPU	1		563.58		X			
		FRIGO SOLAIRE SUNDANZER drc 165	05 Mai 2009	CRS	BUKA VU	1	BIJOMB O/HPU	1		563.58		X			
										<b>10,60 9.24</b>					
<b>6</b>	DISTRICT SUD/UVIRA	MOTO YAMAHA 125 DT + CASQUE	11 Juillet 2007	CRS	BUKA VU	1	DS Sud	1	DE02X- 037562	3,230. 00			X		
		GROUPE ELECTROGENE 2.3 Kva	11 Juillet 2007	CRS	BUKA VU	1	DS Sud	1	368913	800.00		X			
		ORDINATEUR, ECRAN PLAT OPTIPLEX	28 Fevrier 2008	CRS/Buka vu	BUKA VU	1	DS Sud	1		649.00			X		
										<b>4,679. 00</b>					
<b>TOTAL GENERAL</b>										<b>106,21 7.39</b>					

**Annex 12**  
**REPUBLIQUE DEMOCRATIQUE DU CONGO**  
**MINISTERE DE LA SANTE**  
**PROVINCE DU SUD KIVU**



**BESOINS TRIMESTRIELS EN PETROLE POUR LES ZONES DE SANTE SUD KIVU**

Ant	Zone de santé	Nbre d'AS fonction	Nbre d'AS PEV	Situation du matériel de la CDF										Total besoins trimestriels en pétrole	Observation
				Congélateur		Sibir		RCW 50 EK		Refrigérateurs solaires Bon	Total réfrigérateur à pétrole				
				BE	ME	BE	ME	BE	ME		BE	ME	Total		
1	Bagira-Kasha	8	8	1	0	3	0	3	0	1	7	0	7	630	
2	Bunyakiri	25	24	1	0	4	0	8	0	1	13	0	13	1170	
3	Ibanda	12	12	0	0	4	1	1	0	1	6	1	7	630	
4	Idjwi	21	21	1	0	3	2	3	0	1	7	2	9	810	
5	Kadutu	11	11	2	0	2	0	4	0	1	7	0	7	630	
6	Kalole	28	28	1	0	7	0	7	1	1	15	1	16	1440	
7	Kalonge	16	16	0	0	4	1	5	1	1	10	2	12	1080	
8	Kamituga	20	20	2	0	6	1	1	0	1	8	1	9	810	
9	Kaniola	15	15	0	0	4	0	4	0	1	9	0	9	810	
10	Katana	17	17	1	0	7	0	3	1	1	11	1	12	1080	
11	Kaziba	12	12	1	1	5	2	2	0	1	8	2	10	900	
12	Kitutu	22	22	1	0	3	1	3	0	1	7	1	8	720	
13	Lulingu	20	20	2	0	6	2	7	3	1	14	5	19	1710	
14	Minova	16	16	1	0	1	1	12	2	1	14	3	17	1530	
15	Miti - Murhesa	15	15	1	1	4	0	2	0	1	7	0	7	630	
16	Mubumbano	14	14	1	0	6	1	3	1	1	10	2	12	1080	
17	Mulungu	20	20	1	0	5	1	5	1	1	11	2	13	1170	
18	Mwana	13	13	0	0	3	2	3	2	2	8	4	12	1080	
19	Mwenga	18	18	0	0	4	2	5	0	1	10	2	12	1080	

20		Nyangezi	10	10	0	0	4	1	2	1	1	7	2	9	810	
21		Shabunda Centre	21	21	1	0	7	1	3	1	1	11	2	13	1170	
22		Walungu	23	23	1	0	11	1	2	1	1	14	2	16	1440	
		<b>S/Total 1</b>	<b>377</b>	<b>376</b>	<b>19</b>	<b>2</b>	<b>103</b>	<b>20</b>	<b>88</b>	<b>15</b>	<b>23</b>	<b>214</b>	<b>35</b>	<b>249</b>	<b>22410</b>	
23	Uvira	Haut Plateau d'Uvira	21	20	0	0	3	0	5	1	1	9	1	10	900	
25		Lemera	20	20	1	0	4	10	3	0	1	8	10	18	1620	
26		Nundu	21	21	1	0	5	1	3	1	1	9	2	11	990	
27		Ruzizi	16	12	1	0	4	1	5	1	2	11	2	13	1170	
28		Uvira	21	16	1	0	3	1	2	0	1	6	1	7	630	
		<b>S/Total 2</b>	<b>99</b>	<b>89</b>	<b>4</b>	<b>0</b>	<b>19</b>	<b>13</b>	<b>18</b>	<b>3</b>	<b>6</b>	<b>43</b>	<b>16</b>	<b>59</b>	<b>5310</b>	
		<b>Total Province</b>	<b>476</b>	<b>465</b>	<b>23</b>	<b>2</b>	<b>122</b>	<b>33</b>	<b>106</b>	<b>18</b>	<b>29</b>	<b>257</b>	<b>51</b>	<b>308</b>	<b>27720</b>	

Commentaire : les besoins en pétrole = réfrigérateur à pétrole x 30L/mois X 3 mois.

Fait à Bukavu le 29 avril 2011

Dr Augustin MILABYO, MCP-  
PEV/SK

## Annex 13

### ZONES AYANT DÉJÀ RECU DES INTRANTS DE PLANNING FAMILIAL

<b>NO</b>	<b>DESIGNATION</b>	<b>STOCK DISPONIBLE</b>	<b>CONDITIONNEMENT</b>	<b>BAGIRA</b>	<b>IBANDA</b>	<b>KADUTU</b>	<b>KAZIBA</b>	<b>NYANGEZI</b>	<b>TOTAL</b>
1	DEPO PROVERA	96	Carton / 400	15	30	21	10	20	96
2	DIU	518	Piece	100	200	100	100	18	518
3	MICROLUT	4551	plaquette	500	1000	1551	1000	500	4551
4	JADELLE	170	Piece	30	50	50	20	20	170
5	CONDOM MALE	232	carton /3000	50	50	50	10	10	170
6	CONDOM FEMININ	21	carton / 4000	5	5	5	3	3	21
7	COLLIER DE CYCLE	26	carton/500	5	5	6	5	5	26

**VILLAGES CIBLES POUR LES ACTIVITES IHP (PROSANI)**

(Annex 14)

<b>N°</b>	<b>ZONE DE SANTE</b>	<b>AIRE DE SANTE</b>	<b>VILLAGE CIBLE</b>
1	<b>Walungu</b>	Mwendo Ikoma Kalole Cagombe Rushindye	Mukungwe Kasheke Nakago I Ikulubi Ibamba
2	<b>Mubumbano</b>	Labona Cihusi Mubumbano Cihusi Mubumbano	Nkanga Mussa Karambi Cihusi Mususu
3	<b>Kalehe</b>	Bushushu Luzira	Cishenyi Kanyunyi 2 Kabushunju Mishebere Cibanda
4	<b>Katana</b>	Kabamba Kabamba Ihimbi Ihimbi Mugeri	Cifinjo Luhamagaliro Ihimbi Mukaza Mwanda
5	<b>Miti-Murhesa</b>	Mushungurhi Kavumu Buhandahanda Cifuma Mulungu	Bugushu 1 Buloho Bunyunyi Cifuma Kashanja
6	<b>Kaziba</b>	Cirimiro	Cirimiro

		Buzonga Namushwaga Cihumba Kasheske	Karhwa Lukube Mugogo Nacibundu
7	<b>Nyangezi</b>		Kalongo Cishadu Kamina Munya Cibimbi
8	<b>Ruzizi</b>		Kabunabo Biriba Rutanga Kashatu Nyakabere I
9	<b>Minova</b>	Bobandana Bobandana Buhumba Minova Mucibwe	Buganga Rucunda/Majengo Vahe Kabuya Buhomboji/Kitembo
10	<b>Bunyakiri</b>	Maibano Miowe Mingazi Hombo Sud Irangi	Maya Mushafe Pendeza Amsar III Mashere
11	<b>Mwana</b>	Ciburhi Ciburhi Ifendula Mulama Buhamba	Ciburhi Kakoma Cibanda Ishunda Buhamba Centre
12	<b>Kitutu</b>	Kigumo Byonga Cobader/Mitobo	Makalanga Ibenga Mitobo

		Kagelagela Mapale	Kabilongo I Sawa
13	<b>Bagira</b>	Nyamulinga Uhaki/Burhiba Uhaki Makoma Lunu	Quartier D Mulimbilimbi Mulambula Fariala Lugamba
14	Nyantende	Igoki Buhozi Mudusa Mumosgo Ishungu	Igoki Kabungo Bukali Chishugi Kabanda
15			